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ABSTRACT

The focus of this book is on the identification of practical knowledge and skill needed and an action plan to implement prevention programming in schools. The text is written as a resource for practitioners, students, and faculty in school counseling. It is designed to facilitate development of knowledge necessary to implement comprehensive prevention efforts addressing substance abuse and other problem behaviors of youth across school curricula and extracurricular activities. The school counselor is identified as the professional best positioned in the school to initiate the changes needed to implement a comprehensive prevention program. A "prevention for change," the specific steps needed, is provided. Chapters include: (1) "Introduction"; (2) "Prevention of Substance Abuse"; (3) "Prevention: The School Context"; (4) "The Comprehensive School Prevention Program"; (5) "The School Counselor's Role"; (6) "Special Topics"; and (7) "Prescription for Change." Appendixes include: (A) "Common Drugs of Abuse"; (B) "Effects of Individual Drugs"; (C) "Stages of Dependency and Addiction"; (D) "A Self-Administered Short Michigan Alcoholism Screening Test (MAST)"; (E) "SARDI Substance Abuse Symptoms Checklist"; (F) "Twelve Steps"; (G) "Substance Abuse Treatment Approaches"; (H) "Assessment Instruments." (Contains 124 references.) (Author/ADT)

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Preventing Substance Abuse

A Guide for School Counselors

Amos Sales

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About the Author

Dr. Amos Sales has devoted his academic, research, and service efforts over the past 35 years to human resource development within education and rehabilitation. His recent efforts have been focused on the application of prevention concepts and practices to professional preparation and development of teachers and counselors. Since 1988, Dr. Sales has published sixteen (16) articles and one (1) training manual related to prevention of substance abuse. He has co-edited *Preparing Tomorrow's Teachers in Substance Abuse Education; A Curriculum for Teacher Education*. He also edited a text titled, *Substance Abuse and Counseling*.

Dr. Sales' significant professional contributions have been recognized at local, state, and national levels through the receipt of 31 citations, certificates or awards. He is Past-President of the National Rehabilitation Association and of the National Council on Rehabilitation Education (NCRE). In 1998, Dr. Sales received the highest award provided by the NCRE, the *Distinguished Career Award*. In 2000, he received the Department of Education's *RSA Commissioner's Award* for distinguished achievement and distinction in rehabilitation education; and in 2002, he received the American Counseling Association's *Ralph Berdie Research Award*.

Preface

Ours is a society impacted by increasing substance use and abuse. Of major concern is that substance experimentation and first use is occurring at earlier and earlier ages. Substance abuse is not an individual problem. It affects all of us in some way and has a widespread negative impact on our society.

Conservative estimates are that one in three adults in the United States abuse illegal drugs, alcohol, or prescription medications. Another one in four are addicted to nicotine. While the emotional cost to these individuals and their families cannot be quantified, the economic costs in terms of health care and highway and work accidents is, at least, a staggering $300 billion yearly. The emotional and economic costs of incarceration related to substance abuse are immeasurable.

Given the enormity of the substance abuse problem, research indicates there is little or no hope in overcoming it through treatment. Treatment is not that effective. It is difficult to implement, expensive to deliver, and produces minimal client gain. Only a little over 50 percent of those needing treatment can access it. Once they access it, only half continue in treatment. Of those who continue, fewer than two of ten remain drug-free.

The greater potential for impacting the substance abuse problem is through prevention. However, my 25 years of experience in treatment and prevention of substance abuse, including preparing counselors, developing teacher education curriculum, and implementing prevention programs in schools, indicates there is major resistance to accepting prevention, which research and logic show is the answer.

Almost everyone can envision and would endorse the vision of schools, society, and communities without the negative impact of illicit drugs. This would be a society that: 1) endorses, funds, and supports treatment, not punishment, for addiction; 2) has professional sports that are drug-free and steroid-free; 3) reflects the responsible use of legal and prescription drugs; and, 4) has a national policy of management, not a "war on drugs." This society would have communities free of illegal drug trafficking and related criminal behavior and violence and characterized by activities and programs supporting healthy living and responsible use of alcohol.

Schools in this vision would be free of drop out behavior, alcohol abuse, binge drinking, snorting, sniffing, and smoking. Schools would be characterized by students and staff who are empowered to continue their own cognitive and personal growth and who participate with one another collaboratively to enhance the environment. If an individual drug problem occurs, it would be handled supportively with resources available to meet the individual's needs. All school activities would be drug-free by choice.

The above vision could be reality. Enough research on effective prevention strategies exists. However, my experience indicates the main reason why the vision cannot become reality is that no one profession or group sees the substance abuse problem and its elimination as its responsibility. In my work in this field, I have been able to convince many teachers that substance abuse prevention is part of their generic teaching responsibility, but found it more difficult to convince principals and particularly teacher educators of this. I have co-edited a text now used in over 33 higher education institutions on how to integrate teacher knowledge and skills in prevention into required college teacher programs. However, the vast majority of teacher-educators do not see substance abuse as "their" problem. Educators in psychology, school psychology, school counseling, mental health counseling and rehabilitation counseling do not either.

A very important question is, "Who is responsible for implementing the vision of an illicit drug-free society?" The medical practitioner, lawyer, businessman, correctional officers, court personnel, policemen, city, county, state and national elected officers, the President, educators, counselors? All are in part, but no one is in total. The more important question is, "Who accepts the responsibility?" None of these professionals do as a group and only very few within them individually do. Therein is why the "drug problem" continues to result yearly in major tragedies in the lives of young and old in our society. Therein is why this text is written. We each individually must do what we can to begin to impact positively on the substance abuse problem. The reality is that the change needed to impact positively must begin with each of us if change is to occur. Individually, we cannot wait for others to begin to bring about the changes needed to support prevention as the answer to substance abuse. There is no doubt that the responsibility is ours. Change must begin with us. It must begin with you.

The focus of *Preventing Substance Abuse: A Guide for Counselors* is on the identification of practical knowledge and skill needed and an action plan to implement prevention programming in schools. The text is written as a resource for practitioners, students, and faculty in school counseling. It is designed to facilitate development of knowledge necessary to implement comprehensive prevention efforts addressing substance abuse and other problem behaviors of youth across school curricula and extracurricular activities. The school counselor is identified as the professional best positioned in the school to initiate the changes needed to implement a comprehensive prevention program. A "prescription for change," the specific steps needed, is provided.

The text is organized in a sequential delivery of the knowledge needed to initiate prevention programming. Chapter 1 provides a background discussion and rationale for emphasizing prevention in schools. Chapter 2 provides a brief overview of substance abuse as a problem in our society, particularly with youth. Causation and prevalence of substance abuse are discussed. A definition, models, and purpose of prevention are addressed. Chapter 3 discusses the major areas of influence and needed change within the context of the school to insure that effective prevention programming can be implemented. Chapter 4 identifies the four major components of a comprehensive school prevention program. These are: 1) a K-12 prevention curriculum; 2) teacher competencies and skills; 3) school climate and extra-curricular activities; and 4) family and community support. Chapter 5 provides a rationale for the school counselor being the professional best positioned to implement prevention efforts in schools. A brief history of guidance and counseling is provided and possible strategies for prevention program implementation linked to the Comprehensive School Guidance Program strategies are discussed. Barriers to implementing prevention and the importance of the individual school counselor accepting the role of change agent in the schools are identified. Chapter 6 provides information on a variety of special topics such as assessment, evaluation, funding, and policy issues related to prevention. Chapter 7 provides a "prescription for change," the specific steps that school counselors need to follow to implement a comprehensive prevention program.

The author's intent is to provide a stimulus for action on the part of the reader. The substance abuse and related problems among youth, such as violence, suicide, and teen pregnancy represent major tragedies that could be prevented. Knowing this and knowing how to implement prevention programs in schools professionally obligates the school counselor to act, to facilitate the change needed to prevent these tragedies. By doing so, you can make a difference in thousands of young lives.

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Preventing Substance Abuse

A Guide for School Counselors

Amos Sales

Chapter One

Introduction

This chapter provides background information related to the author's experiences in implementing substance abuse prevention efforts within schools and within colleges of education. Findings and conclusions based on these experiences are provided.

Background

The concepts, ideas, and proposals related to school counseling and prevention within this text resulted from a most fortunate series of events that introduced me to prevention in 1986. That year, a private individual conveyed to the University of Arizona Foundation that he would be receptive to proposals that might impact the substance abuse problems of youth in our society. The College of Education was identified administratively as the academic unit to respond, and my Dean asked me to develop the response. With a twenty-year career in rehabilitation education and some clinical experience in the treatment of substance abuse, I was the person within our college closest to having expertise in the donor's area of interest.

Within a week of being tapped for this duty, I conducted an intensive literature review and developed a proposal for funding a comprehensive community-based prevention effort. Within another two weeks, the donor had reviewed the proposal and had committed to a private gift of one million dollars to implement it. The donor's primary interest was in our emphasizing the component of the proposal designed to insure that graduates of the College of Education's teacher education program at the University of Arizona had the skills to serve as prevention agents with students. At first, addressing this donor interest did not seem especially daunting; however, it was not long before I, and everyone related to the Smith Project, named after the donor, realized that very little work had been done with a specific research base in prevention education and even less existed in relation to prevention and teacher preparation.

Once the project was funded, I agreed to serve on the project as Assistant Dean for Prevention Education with overall responsibility for developing and implementing the project. After the Dean and I decided to utilize the funds donated for a major effort versus smaller ones limited to the interest, I developed a project staffing pattern of a Director, an Editor, a Researcher, an Education Specialist, and a Trainer-Consultant and began the process of recruitment. We first hired a Director, who then participated in employing four other doctoral level staff, all with prevention related experience. The combined efforts of this group over four years led to implementing comprehensive prevention programs in 13 Tucson public schools, assessments of substance abuse problems in over 200 Arizona schools, the development of a University of Arizona Athletes Speakers Bureau, and — in response to the donor's primary interest — the development of an infusion curriculum that can be used by colleges of education to insure graduates have knowledge and skill in prevention.

It was agreed that the first project effort would have to be a comprehensive review of research to identify the scope of the substance abuse problem in the United States, its impact on youth and schools, and related school prevention responses to it. We quickly found the scope of the problem, as many knew and had researched, to be enormous. Forty million United States citizens use drugs illegally each year. The negative impact of this on industry, hospitals, accidents, and crime is estimated to cost a third of a trillion dollars each year. Drug trade is estimated at over a $400 million a day business with prison space not adequate to hold those convicted of a drug-related crime. Yearly, drug-related fatalities parallel the death toll of the Vietnam War (Robert Wood Johnson Foundation, 1995).

Drug use and drug-related problems of school-aged youth are identified as outlined more recently by McWhirter, McWhirter, McWhirter, & McWhirter (1998):

- The U.S. Public Health Service reports that about two-thirds of all high school seniors have used illegal drugs; 90% of high school seniors have used alcohol.
- Seventy-seven percent of eighth graders report having used alcohol and 13.5% of eighth graders and 27% of

seniors had five or more drinks at least once within the previous two weeks.

- More adolescents are experimenting with drugs at younger ages, especially before age 15.
- In the last decade and a half, the rate of completed suicide among children 10 to 14 years of age increased by 75%, and increased 34.5% among 15- to 19-year-olds. Each year 7,000 teenagers commit suicide. Suicide is the second leading cause of death for those 10 to 24 years of age.
- Increasing numbers of children under age 15 are becoming sexually active. About 30% of young adolescents report having had sexual intercourse by age 15. Fully one-fourth of all adolescents will be infected with a sexually transmitted disease before they graduate from high school.
- Only 60% of young teenagers use contraceptives at first intercourse, and they are slow to practice contraception thereafter. Teenage girls typically will not use contraceptives until six to nine months after they have become sexually active, and by that time approximately half of them are already pregnant.
- Between 1940 and 1991, the percentage of births to adolescent girls rose from 14% to 69%. In 1992 the teen birth rate dropped 2.3% from the 1991 level and has held constant ever since. Unfortunately, the proportion of births to unmarried teens has reached the highest levels ever recorded.
- Unmarried 13- to 19-year-olds who give birth have few social resources, lower educational attainment, reduced potential earnings, and limited or nonexistent support by the baby's father. The children they bear tend to be underweight and less healthy than average as

teen mothers are much less likely than older mothers to receive prenatal care.

- Eleven percent of U.S. young people drop out of high school before graduation. In many urban areas the dropout rate is considerably higher. Students with low-income, low-skill, low-education family backgrounds are about twice as likely to drop out of school as are students from affluent families.
- Minority students are especially vulnerable to dropping out of school with 14% of African American and 28% of Hispanic youths withdrawing without a diploma. Dropout rates for Native Americans are considerably higher.
- The National Institute of Eduction concluded that nearly 3 million students and teachers are crime victimsin U.S. secondary schools every month. Additionally, crimes involving handguns committed by urban high school students increased significantly in the 1980s and early 1990s.
- The National School Boards Association found that of 720 school districts surveyed in 1993, 82% reported an increase in school violence in the past five years.
- Youth violent death rates increased 6% between 1985 and 1992. In 1992 nearly 12,000 teens died a violent death.
- For African American teenagers, murder is the major cause of death.
- The U.S. Senate Committee on Delinquency estimated that school vandalism costs our nation more than $600 million each year (pp 5-6).

The consequences of behaviors leading to substance abuse, dropout problems, teen pregnancy, sexually transmitted diseases, aggressive behavior, and violence represent major tragedies in young people's lives. These are tragedies that could be prevented by implementing prevention programming.

Given the enormity of the drug abuse and related problems, the true impact of drug abuse is seen in the fact that those who become addicted to drugs have little or no hope of being able to overcome this addiction through treatment. Research indicates that the recidivism rate, the percentage who once "cured" then return to abuse of substances, for treatment interventions across all forms of addiction is between 80 - 90%. Thus, once addicted, only about one in ten is able to continue to be alcohol or drug free. Unfortunately, many in our society do not have even this small hope of "cure" in that treatment resources are inadequate to meet the need. These findings reinforced our belief that the greatest potential for positively impacting this drug abuse problem is through prevention. Prevention efforts are intended to keep a person or group of persons from using drugs. Prevention by definition is the creation of optimal conditions that nurture and sustain the healthy development of individuals, families, and communities (Loftquist, 1989). It is an active, assertive process of creating conditions and/or personal attributes that promote the well being of people. Effective prevention efforts need to be community-based and to include schools.

Given these early findings, staff of the Smith Project began the development of the prevention concepts and ideas presented in this text, all of which are well grounded in research and linked to school practice. Early on, the project's research identified a wide variety of school prevention efforts, represented by one or two targeted efforts at prevention, which had little or no research base. No college of education programs were addressing skill development in prevention as a requirement within their curriculum. What research existed relating to prevention and teacher education indicated that simply adding another course or two in this area would not be the answer. A more comprehensive approach would be needed to develop a college curriculum that insured teachers had the knowledge and expertise needed to serve as prevention agents within schools.

With a commitment to have our project activities grounded in the actual school experience, I also requested and received, in 1987, a U.S. Department of Education grant award in Substance Abuse Education in the amount of $257,486 for 10/1/87 through 9/30/90. This grant funded a cooperative effort, entitled Project Breakthrough, between the Smith Project and the Tucson Unified School District (TUSD) designed to develop and implement a model drug and alcohol abuse prevention and education program. This project helped validate the process for implementing effective prevention programming within schools. ***Project Breakthrough*** was designed to support the development of prevention efforts in five middle schools and eight elementary schools, the "feeder" schools of Tucson High Magnet School. These schools had a high evidence of student drug and alcohol abuse, a low socio-economic neighborhood, and a two-thirds ethnic minority student enrollment (primarily Hispanic and Black), a high academic failure rate, and a high percentage of dropouts, suspensions and expulsions. *Project Breakthrough* was based on the premise that each local school had its own identity and could develop an action plan based on individual school needs to be effective. School Impact Team training was delivered at each school site to five to seven member teams — administrators, teachers, parents, community representatives, nurses and counselors. The objectives of the *School Impact Team* training were to:

(1) implement a K-12 curriculum on substance abuse prevention;
(2) obtain a realistic awareness about alcohol and drug use/misuse/abuse and its effects on the student, the school, the family, the community;
(3) increase the knowledge about warning signals of chemical misuse/abuse dependency;
(4) develop positive attitudes and skills necessary for the building of a supportive school atmosphere;
(5) develop and implement sound action plans to face the issues of chemical misuse in the school setting; and
(6) develop current, appropriate liaisons with resources identified within the community for use within the school program.

With experience gained with this model, TUSD later replicated a modified version of this effort in the feeder school patterns of each of its nine other high schools. Project Breakthrough and the experiences gained in implementing it frame much of the context and recommendations contained in this publication.

A major project finding was that, in order to respond to the problems of substance abuse among students, teachers need to develop certain competencies, knowledge, and skills to be effective in drug and alcohol abuse education and prevention (Jones, Kline, Habkirk, & Sales, 1990). These competencies, knowledge, and skills are traditionally not addressed but need to be addressed in teacher education programs and relevant teacher in-service training. A strategy to do this was identified; and over a four-year time frame a model preservice curriculum was developed. This curriculum integrates or infuses necessary substance abuse prevention/education competencies, knowledge, and skill development into coursework required to complete a college of education teacher preparation sequence of study. For a variety of reasons supported by research, this integrating of the required teacher knowledge, competencies and skills into currently required courses within teacher education programs was decided upon as the more effective way to accomplish this curriculum development as opposed to adding on a course or courses. Such integration provides the potential for college faculty to realize the importance of this issue and develop ownership of it in relation to their own teaching. The first draft of a model curriculum manuscript was completed in the Spring of 1990. A national field test involving me and staff providing training on the use of the curriculum with faculty at four higher education institutions (New York College, Grambling, Concordia, and Adams State) proved to be a means of testing with colleagues not only the curriculum but its underlying beliefs and assumptions regarding prevention. This field-test experience resulted in some revision of the curriculum which was finalized in the academic year 1990-1991 and is titled *Preparing Tomorrow's Teachers in Substance Abuse Prevention: A Curriculum for Teacher Education*, (Moore, Sales, & Fenstermacher, 1991). Other specific outcomes of the project are identified in monograph form (Sales, 1990).

A project finding of potentially much broader impact than prevention of substance abuse alone is that the components of a school-based comprehensive prevention program related to drug or substance abuse are also required for prevention efforts related to other behavioral problems of youth. Suicide, teen pregnancy, "dropping-out," aggressive behavior, and criminal behavior all require the same core K-12 curriculum, teacher competencies and skills, extra-curricular activity, and family and community support as is needed for an effective prevention effort with substance abuse. An effective substance abuse prevention program will impact positively these areas as well.

Several other project activities are worth noting here in relation to this text. One was the development of a university athlete "Speakers' Bureau" for schools during the Fall Semester 1987-1988. This "Speakers' Bureau" coordinated prevention presentations by athletes or coaches at different schools within the Tucson metropolitan area. It is estimated that over 10,000 students received an anti-drug message through the "Speakers' Bureau" during three years of this project activity. The "Speakers' Bureau" is currently on-going as part of the University of Arizona's Athletic Department. The project also developed a survey instrument that was utilized in over 200 schools within Arizona to identify substance abuse problems of students. It also sponsored or co-sponsored approximately 100 presentations linked to coursework delivered at the University during the tenure of the project. These presentations were made to model the delivery of the curriculum and to educate professors, college students, teachers, and other school personnel.

Prevention in Schools

Based on the findings from research and the experiences with the Smith Project, it is assumed that comprehensive prevention programs are essential within schools to prevent and ameliorate the problems of children and adolescents. A K-12 prevention curriculum targeting all youth and effectively delivered by facilitative teachers is required. Extra-curricular activities, policies, and practices must send a drug-free message. If a student begins actual drug use activities, the availability of specific treatment interventions followed by follow-up programs is critical. All of these prevention strategies can and need to be effectively implemented within the school for there to be a prevention impact.

Components

The intent of the K-12 prevention curriculum is to maintain or increase the educational achievement, social coping skills, and mental health of large numbers of children. Ideally, the curriculum is health-oriented, emphasizes personal development, and addresses development of basic life-skill competencies such as problem-solving and decision-making skills, communication skills, social skills, and impulse control. Such a curriculum, appropriate to initial skill level, cultural backgrounds, and social class variables, should be progressive and developmental as students move through school. The curriculum should include information on study skills and time management, how to make friends, how to manage emergencies, how to avoid or report abuse, how to prepare for intimate relationships, how to prevent pregnancy, and how to avoid drug abuse and resist peer and media pressure to engage in behavior that has negative consequences.

This information and learning should be ongoing components of the curriculum rather than one-session classes. Problem solving, decision making, empathy, communication, assertiveness, and coping skills should also be ongoing components (Moore, et al, 1991).

A second major component of comprehensive prevention programming relates to the ability of all teachers, with support from and in consultation with school counselors, psychologists, and social workers, to be able to facilitate not only cognitive but personal growth of students. They additionally must be able to deliver and teach a skill-based curriculum addressing cognitive and life skills, avoidance of substance use and delinquency, and sex education. The ability to teach the curriculum in a way that facilitates student personal as well as cognitive growth (Witmer & Myrick, 1980) is essential to prevention. This teacher ability and student learning gained with a prevention curriculum will have far-reaching effects for young people and for society as a whole.

In addition to curriculum prevention efforts, schools need to have, as part of their prevention programming, extra-curricular activities that are anti-drug use by nature. Clear policies and procedures must exist on specific treatment approaches for individuals who have actually begun to engage in the behavior. A specific treatment approach, such as a smoking reduction treatment group, should be designed to change addictive behavior by increasing knowledge of the problem behaviors and providing alternative behaviors and coping skills. Similar treatment approaches are needed to help students resist other outcomes of social pressure, such as becoming involved in delinquent behavior, engaging in unprotected premature sex, withdrawing from school, or withdrawal and depression. Additionally, therapy options for those with major substance abuse problems need to be available within the school or the community. The problems of children and youth have multiple antecedents, and prevention and intervention efforts in schools must focus on many causal factors if they are to be effective.

Prevention in schools begins with adequate comprehensive preschool, compensatory programs, such as Head Start, and before- and after-school programs. In these programs, a prevention curriculum needs to be in place to teach social and cognitive-behavioral skills to all children. As children develop chronologically and behaviorally, prevention efforts expand to include programming aimed at specific groups or individual children.

Developmental Considerations

It became obvious very early in the project that age-appropriate prevention efforts were an important consideration in schools. At the primary level (grades Headstart-3), students tend to be physically active, yet require regular rest periods. For appropriate emotional development, these children need to receive positive encouragement, recognition, praise, patience, and adult support. Socially, primary students are quite self-centered and demand attention. They are sensitive about being left out and desire group approval. Thus, it is important to help students develop socially acceptable behaviors in work and play. Students who are deficient in social skills have an increased chance of developing drug use problems when they are older (Hawkins, Catalano, & Miller, 1992). Interventions should begin as early as possible for children who begin to engage in risky behavior such as aggressiveness, withdrawal, and suicide gestures or children who exhibit negative emotions such as depression, anxiety, or hostility.

At the intermediate level (grades 4-6), most girls and a few boys experience tremendous growth. Girls become taller and heavier than boys, reach puberty and become interested in boys. On the other hand, many boys show little interest in girls. Social friendships divide along peer sex lines. There is a strong need to be recognized and accepted within this peer structure. Students begin to show qualities of leadership, responsibility, cooperation, group planning, and independent thinking, as well as learning to abide by group decisions. Intermediate level students continue to need security and acceptance from parents and teachers and require much encouragement, affection and understanding.

Teachers of intermediate-level students must concern themselves more than primary teachers with problems of student motivation and emerging independence. If possible, teachers at this level should play an even more facilitative role. Such should be easily accomplished with this age group since they like to talk and express ideas and are eager to acquire new skills, explore, experiment, solve problems, be challenged, use initiative, and be creative in their self-expression. Like primary teachers, most intermediate teachers have self-contained classrooms and can make the environment rich in materials and opportunity. They can plan how and when to integrate ideas across academic areas and plan for interactive, student-centered learning. Such learning represents an effective prevention strategy in that it helps the students make connections between what they learn and how they can apply it to their lives.

Puberty does not occur at the same chronological age in children. Anxiety often accompanies this physical growth and change. Because adolescents now mature physically at a younger age than in the past, they may be exposed to stresses for which they may not be prepared psychologically. Many try to cope through drug use, as evidenced by the decline in the initial age for drug experimentation. Those involved in early drug experimentation are at greater risk for abuse and related problems.

Early adolescence is a time of heightened self-consciousness which can foster feelings of low self-worth. Teachers can counter this possibility by structuring class activities in ways that support individual and group success and provide other success opportunities such as volunteer work to focus on the welfare of others. At this time, the peer group or often a best friend is a catalyst in initiation of drug use. Data show that the influence of the peer group can be mobilized to prevent the onset of substance abuse during early adolescent years through use of peer influence, peer teaching, and peer counseling (Vaughn & Litt, 1990). Given this, the teacher needs to be able to establish a classroom climate that fosters individual and group acceptance, security, introspection, and nurturance to facilitate meaningful classroom learning experiences related to substance abuse.

High school students are faced with enormous decisions regarding their lives. Staying drug-free is but one of these challenges. High school students are, to differing degrees, near the end of their physical—but not emotional, social or intellectual—maturation. They are beginning to be concerned about their future. They experiment with efforts to be self-reliant, but remain desperately in need of group identification and acceptance. They become sensitive to their own inadequacies, and this may be expressed through immature or antisocial behavior. They expect fair, consistent and non-judgmental treatment, and need to be challenged to develop critical thinking skills and to become actively involved in their own learning. To meet these needs, high school teachers should organize learning situations around the student rather than the subject. Teachers must stay attuned to the interests and activities of their students in order to help them explore issues that affect their lives. Because individual students have different learning styles, teachers need to provide alternative learning experiences in a manner that allow students to apply new information rather than simply memorize facts for tests and other assignments.

Research Support

As will be addressed throughout this text, process and outcome research studies over the past few decades on school-based abuse programs continue to provide support for implementing the four major curricular and extracurricular prevention components identified in this text (Adair, 2000; Buncher, 1997; Coker, 2001; Marsiglia, Holleran, & Jackson, 2002; Shin, 2001; Short, 1998; Westberg, 2001). Providing these components in broad and comprehensive ways best addresses the range of prevention needs of youth (Horn & Kolbo, 2000; Monti, Colby, & O'Leary, 2001).

While evaluation methodology problems continue to exist with prevention interventions targeting specific populations (e.g.., females, high risk youth, disability groups), they have also proven to be effective (Amaro, Blake, Schwartz & Flinchbaugh, 2001; Brown & Block, 2001; Cosden, 2001; Erhard, 1999; Horn & Kolbo, 2000; Melton, Chino, May, & Gossage, 2000; Monti, Colby, & O'Leary, 2001; Namyniuk, Brems & Kuka-Hjindin, 2001).

The importance of parental and community involvement also finds support in research and effective strategies have been identified (Hogue, Liddle, Becker, & Johnson-Leckrone, 2002; Join Together, 2000; Melton, Chino, May, & Gossage, 2000; Westberg, 2001).

Research supports the belief that prevention provides the ultimate key to reversing the use of drugs and empowering individuals, schools, and communities to address their drug problems. Prevention's goal is to develop the personal skills needed to resist the pressures to initially use or continue to use alcohol and other drugs. The most effective strategies for preventing drug abuse, as demonstrated by the research, are outlined and discussed in this text.

Conclusions

The overall Smith Project efforts, programming and curriculum, and much of this text are based on the following conclusions:

(1) The substance abuse problem in the United States can more effectively be addressed through prevention than treatment;
(2) Substance abuse, as well as school drop-out, delinquency, pregnancy, and suicide problems of youth, reflect tragedies in the lives of millions;
(3) School-based prevention programing for all these problem areas have similar components;
(4) Substance abuse prevention programming can be effective;
(5) Substance abuse prevention is not an additional mission for schools;
(6) Substance abuse prevention is closely tied to existing goals in teaching, schooling, and counseling;
(7) Substance abuse prevention reflects and reinforces the best qualities of schooling and outstanding teaching and school counseling;
(8) Substance abuse prevention provides a strategy for renewal of schooling, teaching, and school counseling;
(9) Given the above, we have an individual responsibility to bring about the change needed in schools to be able to implement substance abuse prevention programming; and
(10) The school counselor is uniquely qualified and situated within the school to bring about this change and implement effective prevention programs.

The chapters in this text build upon these conclusions. They discuss the problem of drug abuse, society's and schooling's responses, a model school prevention program, the school counselor's leadership position in insuring it is implemented, special topics, and a "prescription for change," the steps needed to implement the model prevention program.

Chapter Two

Prevention of Substance Abuse

This chapter will provide introductory information for the school counselor defining substance abuse, its history in the United States, causation, and prevalence. A definition and a discussion of the various prevention models and strategies as applied to schools is then presented.

Substance Abuse

Substance abuse is a critical problem in the United States across all segments of the population. Inaba & Cohen (2000) provide data in support of the conclusion that substance abuse is the most prevalent mind disorder, the number one continuing health problem, and the number one prison problem in the United States. Substance abuse, both in rural and urban settings, is widespread and of major impact in our society (Beck, Marr, & Taricone, 1998, National Center on Addiction and Substance Abuse, 2000, Wright State University, 1996). Estimates are that forty-five million Americans attend 140 different kinds of weekly recovery groups. Another one hundred million are trying to help those who are in recovery (Yalom, 1995). Substance abuse appears to be the number one domestic problem in the United States. It has been a source of concern for decades in the United States, where we have the highest usage in the industrialized world. Treatment of substance abuse and addiction is difficult, expensive, produces minimal gains, and has high rates of recidivism (Gerstein and Harwood, 1992). Prevention is the logical alternative to treatment, yet it is more difficult to implement effectively than one might anticipate. Given the high incidence of substance abuse in our society, the economic costs, and the price in human suffering, it is imperative that education professionals, particularly school counselors, are sufficiently prepared professionally to serve as prevention agents with youth (Sales, 1992).

Definition

Educators and the public face a multitude of terms used to identify individual abuse of substances. Addiction, alcoholism, alcohol abuse, drug abuse, and chemical dependency are representative. Most professionals and treatment programs now adhere to the related terms and criteria as identified in the Diagnostic and Statistical Manual IV (DSM IV-TR) (American Psychiatric Association, 2000). The DSM IV-TR "Substance-Related Disorders," identifies "substance dependence" and "substance abuse" as subcategories involving the active use and/or dependency on any mood-altering chemical. Substance abuse refers specifically to the temporary abuse of a substance due to transient stresses. Substance dependence is a more severe diagnosis than substance abuse and is identified as the dysfunctional use of chemicals upon which the individual has become dependent. This dependence is equivalent to what is referred to as alcohol and drug addiction.

Within this text, the term "substance abuse" is used interchangeably with the broad DSM IV-TR and criteria for "Substance-Related Disorders." The term "substance" is used to define alcohol, sedatives, amphetamine, cannabis, cocaine, hallucinogens, inhalants, opioids, caffeine, nicotine, and prescription drugs, as well as legal drugs. A substance or drug is any psychoactive (affecting cognition or emotion) chemical that is illegal or harmful for a minor to use or purchase. The legal nature of some drugs presents different issues related to their use and abuse. While the above substance abuse definition is provided for understanding in further references in this text, the reader must understand that individuals who abuse substances cannot be categorized and defined by their substance abuse problem. An individual with a substance abuse problem is unique in his/her history, pattern of use or abuse, prevention, and treatment needs (Sales, 2000a).

An individual's involvement with substances or substance use is often described as being on a continuum from non-use to dependence. Behavioral addictions (love, sex, work, gambling, running, etc.) follow similar stages of involvement. The first stage is experimental and based on curiosity. It is sporadic and relates to a desire to test the effects of the substance. This use may be influenced by modeling of peer groups or parents. Next is recreational use, which is occasional and situationally controlled. It is associated with social or recreational activities in which the user would usually take part even if drugs were not present. Enjoying the experience is characteristic of this use where little or no effort is devoted to seeking out the drugs. Next in the sequence is early dependence. Here the individual begins to believe the substance, person, or activity will improve his/her life and seeks it out for such improvement. Negative features of involvement are not acknowledged. The end point of the continuum is dysfunctional use, where the individual begins to need a substance, person, or activity to feel normal. Friendships, work, and health begin to suffer because of the abuse. Denial, anxiety and depression begin to occur. The individual feels miserable and uncomfortable when involved with the substance, person, or activity but is not willing to stop involvement. He/she must have "it" to survive (Buck & Sales, 2000). An awareness of this continuum leads to the obvious conclusion that there are varying degrees of involvement with substances and varying degrees of substance abuse. Some users are very conventional in every aspect of their lives except for their drug abuse while others are deeply involved in dysfunctional drug use and/or criminal activity to support it.

Until recently, the emphasis in prevention and treatment has been on the substance, i.e., "the demon rum," as if it were inherently alive and evil in itself (Sales, 2002). Fortunately, the current view is that substance abuse is a function of the person involved rather than the substance itself. Heavy dependence on drugs depends on the person, not the drug. Given all the potential physical, cultural, and social influences, it is the personality of the user that determines how important substance use becomes in relation to his or her life. Thus, it is the person who must be targeted in prevention and treatment of problems of substance abuse.

Historical Overview of Drug Use

Alcoholic beverages have been a part of this nation's past since the landing of the pilgrims who held a high regard for alcoholic beverages and considered them an important part of their diet. Drinking was pervasive because alcohol was regarded primarily as a healthy substance with preventive and curative powers, not as an intoxicant. Alcohol played an essential role in daily rituals and in collective activity, such as barn raising. While drunkenness was condemned and punished, it was viewed only as an abuse of a God-given gift.

The first temperance movement began in the early 1800s in response to dramatic increases in production and consumption of alcoholic beverages. Agitation against alcohol and the public disorder it spawned gradually increased during the 1820s. In addition, the beliefs of Benjamin Rush, related to alcohol being addictive and capable of corrupting the mind and the body, took hold among the general population. The American Society of Temperance, created in 1826 by clergymen, spread the anti-drinking gospel. By 1835, out of a total population of 13 million citizens, 1.5 million had taken the pledge to refrain from using distilled spirits. From 1825 to 1855, the first wave of temperance resulted in dramatic reductions in the consumption of distilled spirits, although beer drinking increased sharply after 1850. A second wave of the temperance movement occurred in the late 1800s with the Women's Christian Temperance Movement, which embraced the concept of prohibition. Recruitment of women into the movement was major and crusades to close down saloons were prevalent. The movement's culmination was the passage of a prohibition amendment in 1919 called the Volstead Act. The social turmoil caused by prohibition resulted in the 18th Amendment's repeal in 1933 (Sales, 2002).

The current prevalent belief about alcoholism is that chronic or addictive drinking is limited to a few highly susceptible individuals suffering the disease of alcoholism. The disease concept of alcoholism focuses on individual vulnerability, be it genetic, biochemical, psychological, or social/cultural in nature. Per this view, if the collective problems of each "alcoholic" are solved, it follows that society's alcohol problem will be solved. Reflective of this belief is "The fault is in the person and not in the bottle." This view of alcoholism has also been the dominant force behind contemporary alcohol problem prevention. Until recently, the principal prevention strategies focused on education and early treatment. Education was intended to inform society about the disease and to teach people about the early warning signs so that they would initiate treatment as soon as possible. A renewed education emphasis has been on the diverse consequences of alcohol use, particularly trauma associated with drinking and driving, fires, and violence, as well as long term health consequences.

The history of nonmedical drug use and the development of policies in response to drug use also extend back to the early settlement of our country. Like alcohol, the classification of certain drugs as legal or illegal has changed over time. These changes had racial and class overtones. Prohibition was a response to the drinking practices of European immigrants, who became the new lower class. Cocaine and opium were legal during the 19th century and were the favored drugs among the middle and upper classes. There were no legal controls on the sale of psychoactive drugs. Opium, cocaine, and morphine were promoted as cures for a wide range of illnesses resulting in more individuals who were addicted proportionally than today. By the end of the 19th century, public concern had grown over the indiscriminate use of these drugs, especially the addictive patent medicines. Opium and morphine were common ingredients in various potions sold over the counter. Cocaine became illegal after it became viewed as predominantly used by African Americans following Reconstruction. Opium was first restricted in California in 1875 when it became associated with Chinese immigrant workers. Marijuana was legal until the 1930s when it became identified with Mexicans. LSD, legal in the 1950s, became illegal in 1967 when it became associated with the counterculture. Until 1903, cocaine was an ingredient of Coca-Cola®. Heroin, which was isolated in 1868, was hailed as a nonaddictive treatment for morphine addiction and alcoholism (Inaba & Cohen, 2000).

In 1906, Congress passed the Pure Food and Drug Act which was designed to control opiate addiction by requiring labels on the amount of drugs contained in products, including opium, morphine, heroin, alcohol, marijuana, and cocaine. The Harrison Act (1914) made it illegal to obtain narcotics without a prescription and imposed a system of taxes on opium and coca products with registration and record-keeping requirements in an effort to control their sale or distribution. As a result of this Act, the number of addicts dropped sharply.

Increases in alcohol consumption as well as illegal drugs during the 1960s and 1970s raised public concern. The 1969 Woodstock Rock Festival highlighted the national celebration of a drug use philosophy. By 1985, it was estimated that 40 million people were using illegal drugs. Prevention issues gained prominence with national pressure resulting in the passage of the 1970 Controlled Substances Act. Under this Act, drugs are classified according to medical use, potential for abuse, and likelihood of producing dependence. The Act establishes maximum penalties for the criminal manufacturer and distribution of scheduled drugs. Public concern also resulted in the creation of the National Institute of Alcohol Abuse and Alcoholism (NIAAA) in 1971 and the National Institute on Drug Abuse (NIDA) in 1974. Both agencies included prevention components. The Omnibus Drug Bill of 1986 created major new legal penalties for use of illegal substances as well as a financial base for the majority of prevention efforts in schools today. It also established the United States Office for Substance Abuse Prevention (OSAP), which consolidated alcohol and other drug prevention activities under the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA). The ADAMHA block grant mandate called for States to set aside 21 percent of federal alcohol and drug funds for prevention. In a 1992 reorganization, OSAP was changed to the Center for Substance Abuse Prevention (CSAP), part of the new SAMHSA, retaining its major program areas, while the research institutes of NIAAA and NIDA were transferred to the National Institute of Health (NIH).

Public policy in the United States has moved toward a perception of alcohol being a dangerous substance as opposed to a cheerful beverage to be used in moderation. A related policy example includes, in 1984, the federal government requiring states to raise the drinking age to 21 or lose a part of their allocated federal highway taxes. In 1988, the Office of National Drug Control Policy was established by the Anti-Drug Abuse Act to restore order and security to American neighborhoods, dismantle drug trafficking organizations, help people break the habit of drug use, and prevent those who have never used illegal drugs from starting. By 1989, all beverage alcohol had to carry warning labels (Inaba & Cohen, 2000).

During the last three decades of continuous and widespread exposure to illicit drugs, there has been a remarkable change in attitude toward drugs from the 1970s to the current popular attitudes. When we recall Jerry Rubin's claim in 1970 that "marijuana makes each person God" and Timothy Leary's recommendations to "turn on, tune in, and drop out," we reflect in social norms far different than the now increasingly acceptable demands for zero toleration of drug use and punishment for casual users. Social attitude has moved from softening of anti-drug laws in the 1970s to renewing their severity at the turn of the century.

Changes in attitude are most dramatically apparent in the case of cocaine. It reappeared about 1970, after the earlier wave of cocaine use (from the 1880s to the 1930s) had been forgotten. As in the first cocaine episode, the drug was perceived as a harmless tonic by expert observers.

As the street price of cocaine dropped and use broadened, the acute and long-term effects alarmed the public, especially those close to users and the users themselves. The stereotypical "cokehead," characterized by being anxious, fearful, paranoid, hyperactive, and out of touch with others, may be the most fear-producing drug image to the American public. "Crack" in the 1980s heightened the negative image of cocaine and accelerated the nation's rollback of drug toleration in general. Crack cocaine use became concentrated at lower socioeconomic levels of society, and a differential of treatment emerged, with legal penalties being greater for "crack" than for cocaine possession.

Some have argued that under legal controls and distribution, drugs will be safe and that availability of the drugs would end turf wars and allow the dollars spent on interdiction to be spent improving conditions in the inner city. However, Americans continue moving toward intolerance of drugs and drug users, and it is unlikely that legal restrictions will be relaxed or eliminated.

The rise of Acquired Immune Deficiency Syndrome (AIDS) adds another source of societal concern about drug use, especially when it involves sharing of needles and sexual contact with intravenous drug users, who have a high rate of AIDS. The debate here has centered on the wisdom of distributing sterile syringes and needles, condoms, and providing methadone without many of the elaborate regulations now controlling this opioid. The full social and medical impact of AIDS lies in the future.

It is assumed that the stress of these societal concerns will tend to restrict rather than relax public policies regarding drug abuse. The question for public policy is the degree to which a growing reliance on law enforcement will be balanced by availability of prevention and treatment programs and sustained support for research (McWhirter, et al, 1998).

Historical Overview of Prevention Programs

During the 1960s, drug prevention programs focused on providing information. Early efforts were based on scare tactics, moralizing, and often inaccurate information. Many programs contained fear-arousing messages regarding the social and health consequences of drug use. This approach was not effective (Center on Substance Abuse Prevention, 1993).

By the 1970s, drug prevention programs began to address personal and social factors that correlated with drug abuse and to provide more accurate information. Affective education became the major preventive approach. It focused on factors associated with the use of drugs and attempted to eliminate the presumed reasons for using drugs. Affective education targeted self-esteem on the assumption that if young people understood their motivations for drug use and had greater self-esteem, they would not want to use drugs. This approach also failed to lower substance abuse rates (Center on Substance Abuse Prevention, 1991).

During the 1980s, prevention efforts began to address comprehensive affective, cognitive, and behavioral strategies. These strategies included developing social competency, social coping skills, and related "life skills." Results, as supported by research, have been promising (Durak, 1995). Twenty years of research support the fact that effective prevention models must incorporate affective, cognitive, and behavioral approaches that emphasize development of personal competence and life skills (Adair, 2000; Buncher, 1997; Coker, 2001; Marsiglia, Holleran, & Jackson, 2000; Shin, 2001; Short, 1998; Westberg, 2001).

Theories of Causation

Individual use of drugs has existed throughout recorded history to enhance a person's pleasure, alter one's state of consciousness, or decrease pain. What has been viewed as excessive use and abuse of substances by individuals has been determined from differing cultural perspectives across time.

To date, no clear etiology or causation has been identified for substance abuse. Many models or theories of causation for substance abuse or addiction have been proposed and linked to various causes such as social learning, imitation, curiosity, risk-taking, anger, and susceptibility to social influences, including marketing. One explanation of causation, the moral model, views substance abuse as a result of individual conscious choice of overindulgence and moral degradation. A cure could be obtained through willpower and a desire to abstain. The biological-disease or medical model identifies substance abuse as a biologically inherited vulnerability to a given substance. Avoidance of the carcinogen is the cure. Behavioral models view substance abuse as a result of faulty learning patterns and related ineffective attempts at stress reduction. Behavioral interventions are emphasized for treatment. Cultural models identify substance abuse as being fostered by cultural factors, social pressures, and environmental conditions. Treatment relates to developing social skills. The majority of practitioners and researchers currently support a biopsychosocial model which holds that substance abuse is developed as a result of a complex interaction of factors identified in all of the above models. This model identifies substance misuse, abuse, and addiction as multifaceted problems that vary across individuals, their cultures, and their families. In this model, multiple strategies of counseling as utilized in the other models are proposed as appropriate to treatment (Sales, 2000a).

Research in support of any of these models is inconclusive. There is no clear consensus as to why people engage in substance abuse, or why some people become addicted while others do not (Erickson, 1998). Despite this, it is important for the school counselor to develop, through a review of various causation models, a conceptual position that attempts to explain substance abuse and related addictive disorders. From this review, the counselor can develop a position upon which he/she can make consistent therapeutic assumptions and decisions to guide counseling practice (Sales, 2000b).

Prevalence

As is the case with terminology related to substance abuse, the difficulty of identifying specific incidence and prevalence data exists. It is difficult in reviewing the literature to estimate with any degree of accuracy the number of individuals who chronically abuse substances. Surveys and self-reports are replete with validity problems. Individuals who abuse one drug often abuse another and their individual reporting of use compounds survey data and makes it very difficult to determine the specific problem. Thus, estimates of the prevalence of substance abuse problems in the population at large range from a low of 2% to a high estimate of 60%.

For the majority of the past ten years, substance use has been viewed by the general population as the primary problem facing our society. Data from the 1999 National Household Survey on Drug Abuse shows that alcohol and cigarettes are the substances most frequently used. A majority of the respondents aged 12 and older reported that they had used alcohol (62.4%) at least once in the month prior to the survey.

About 5% were considered heavy drinkers. The next highest reported use was cigarettes (30.2%), followed by marijuana (5%), and smokeless tobacco (3%). National statistics indicate an increase in drug usage of various substances across all age groups (Shoenborn & Adams, 2001).

Illicit Drugs. The National Household Survey completed by the National Institute of Drug Abuse (NIDA) in 1999 indicated that 7.2% of adults surveyed met the criteria for illicit drug use and dependence. (Shoenborn & Adams, 2001). It supports past estimates that more than 2% of the population, about 5.5 million people, need treatment for drug abuse (Gerstein & Harwood, 1990). One in 15 Americans older than 12 uses illicit drugs. Half of the population over the age of 12 indicate they have used illegal drugs. Additionally, 5% of Americans use marijuana regularly and approximately 2% are regular cocaine or heroin users (Shoenborn & Adams, 2001).

Alcohol. Data indicate 62.4% of Americans 12 years or older are current drinkers of alcohol and 5% are heavy drinkers (Schoenborn & Adams, 2001). Early reports indicate approximately 13.8 million United States citizens had problems with drinking, including 8.1 million who are alcoholics (National Institute of Alcohol Abuse and Alcoholism, 1994). This supports estimates of "heavy drinking" in the United States of 12% with the prevalence of problem drinking among American males considered to be as high as 20 %. More than 500,000 Americans are treated yearly in more than 8,000 inpatient and outpatient alcohol treatment programs.

Prescriptions. Approximately 1.5 billion prescriptions are written each year in the United States. Over the past 25 years, the average annual number of prescriptions per person has increased from 2.4 to 7.5 (Stall, 1996). Investigators estimate that 13% of the men and 29% of the women in the United States use some form of psychotropic drug having an altering effect on perception or behavior. The abuse of prescribed drugs in the United States may be as high as 20% of the general population (Hazelden, 1996).

Nicotine: One in four people, or approximately 56 million, in the U.S. are addicted to nicotine. Fifty million smoke cigarettes and 6.1 million are current users of smokeless tobacco (Inaba & Cohen, 2000).

The above prevalence figures indicate there is a major problem of substance abuse among individuals within our society. The estimates indicate approximately 6% of our population abuses illegal drugs, 12% have problems with drinking, 25% are addicted to nicotine, and conservatively 10% are addicted to prescription medications. Cumulatively, these percentages identify a significant number of the United States population as having a substance abuse problem. Substance abuse impacts in some way all members of our society at all ages.

Of obvious concern related to the abuse of substances in our society is the early initiation to drugs. One in 3 teenagers by age 16 indicates he/she has been approached to buy or use drugs, and at least 4 out of 10 school children say drugs are being sold in their schools. One in 10 high school students has used cocaine at least once and more than 1 in 5 teens have used illegal drugs (Inaba & Cohen, 2000).

Although tobacco and alcohol are usually not thought of as "drugs," they are drugs, and their effects can be as devastating to children and teenagers as illegal substances—in some cases more so. The consumption of tobacco, alcohol, and other legal and illegal drugs creates a tremendous burden for today's youth. The United States has the highest rate of alcohol and drug use and abuse by adolescents among industrialized nations (Johnston, O'Malley, & Bachman, 1995).

The prevalence and incidence of substance use among young children have not been adequately documented, and systematic research on the incidence of substance use among teenagers is equally limited. The National Institute on Drug Abuse Household Survey of 1999 estimates drug use among 12- to 17-year-olds, but it does not assess drug use among younger children. Findings suggest that 80 to 85% of high school students have used alcohol. Those figures do not account for dropouts, who probably have higher rates of substance use. (Schoenborn & Adams, 2001). More research is needed to establish the prevalence and incidence of alcohol and drug use among children and adolescents.

Experimentation with tobacco has been reported as early as age 9 (Sussman, Dent, Burton, Stacy, & Simon, 1993) and personal experience indicates as early as age 6. Substantial numbers of boys experiment with alcohol around age 12; girls begin to drink shortly after this age. Trends suggest that experimentation and the use of both tobacco and alcohol is beginning at increasingly earlier ages. The average age of beginning smokers plunged from 14 to 10 between 1970 and 1990, and the number of girls aged 13 to 17 who began smoking increased 5% in the same period. Among high school students, alcohol and tobacco use remains very high. Approximately 92% of high school seniors had used alcohol, about 47% had tried marijuana, 66% had used cigarettes, and 12% had used cocaine (Kandel & Davies, 1996).

Tobacco and alcohol use among youth is far more frequent than illegal drug use. In 2000, approximately 52% of youths aged 12 to 17 were cigarette smokers, 16.4% were heavy drinkers, of which 66% used illicit drugs (National Clearinghouse for Alcohol and Drug Information, 2001). There has been a trend over the past ten years toward increased use of tobacco, marijuana, and other illegal drugs. Marijuana is the most commonly used illicit drug (28%). Stimulants are next (11%), followed by cocaine (6%), inhalants (6%), psychedelics (5%), and crack cocaine (2%). Young people frequently believe that "everybody" is using illegal substances. However, most report they do not.

Prevention

It is generally agreed among prevention practitioners that the overall goal of prevention is to foster a climate in which:

- alcohol use is acceptable only for those of legal age and only when the risk of adverse consequences is minimal;
- prescription and over-the-counter drugs are used only for the purposes for which they were intended;
- other abusable substances (e.g., gasoline or aerosols) are used only for their intended purposes; and
- illegal drugs and tobacco are not used at all (Office of Substance Abuse Prevention, 2000, p 98).

If success in fostering such a climate is attained, alcohol, tobacco, and other drug problems will be stopped before they start.

Definition

As defined in Chapter 1, prevention is an active, assertive process of creating conditions and/or personal attributes that promote the well being of people. This process involves the creation of optimal conditions that nurture and sustain the healthy development of individuals, families and communities. Its goal is to change the conditions under which undesirable behaviors occur by promoting the overall well being of people through positive action (Lofquist, 1989).

Over thirty years ago, Caplan (1964) suggested that prevention activities could be classified according to three levels: primary, secondary, and tertiary. Primary prevention focuses on strengthening individuals and communities prior to the instigation of detrimental behaviors that may lead to addiction. Secondary prevention refers to those efforts that attempt to intervene in addictive patterns that are harmful to individuals and communities before these patterns have become entrenched and require treatment. Tertiary prevention includes treatment strategies designed to remediate addictive patterns and prevent a downward trend that may result in death and the dismantling of individuals, families and communities. Caplan's classification can be somewhat confusing since it allows any activity to be described as prevention. However, interventions in any of these levels can have preventative effects. Relapse prevention is often considered a next level which includes those efforts designed to support individuals, families, and communities who have stopped on their own or have been treated for addiction. All of these levels are important in a comprehensive prevention plan and will be discussed in some depth in later chapters. It is important for counselors and other professionals to recognize the different levels of prevention and the manner in which their efforts at one level complement interventions in the others.

In the past twenty years, prevention research in addiction has focused almost exclusively on substance abuse. Contemporary researchers and practitioners, however, see many commonalties among addictive disorders (Gold & Miller, 1997) and argue, as is the case in this text, that the application of prevention theory can apply to a wide variety of addictive behaviors such as gambling, sex, eating, and exercise (Blume, 1997, Bushweller, 1995b, Buck & Sales, 2000).

Epidemiological Model

The development of prevention efforts related to substance abuse prevention at primary, secondary, and tertiary levels have been based on numerous causal models of addiction. These models generally reflect trait/genetic determinants, cognitive and attitudinal factors, pharmacological factors, developmental variables, behavioral factors, and socio/cultural influences (Botvin & Botvin, 1997). Most prevention programs address one or more of these factors. In public health, an epidemiological model is used to explain disease as the interplay between the agent of infection, the host, and the environment (Lilienfeld & Lilienfeld, 1994). This model is easily adapted to the area of prevention of addiction, wherein the agent is understood as the drug or the behavior (e.g., gambling), individual characteristics and internal influences (e.g., depression, brain function) compromise the host, and environment consists of those external influences such as media and social norms which have an impact on specific drug use (Vaughn, 1993). Understanding the interaction of these forces is considered paramount in designing and implementing effective prevention programs. This model provides a structure within which to develop and evaluate any primary, secondary, or tertiary prevention effort. Within the comprehensive epidemiological model, sub-models have developed to guide prevention interventions at the levels of agent, host, and environment.

Prevention Strategies

Agent prevention strategies target the drug or addictive behavior itself. Availability, accessibility, and reactions to the drug or behavior on the part of the user become important considerations in prevention planning (Chen & Kandel, 1995). Programs that target the dissemination of drug information and the reduction of drug supply are examples of approaches under this model. Such programs provide awareness and knowledge of the nature and extent of alcohol, tobacco, and other drug use, abuse, and addiction and their effects on individuals, families, and communities, as well as information to increase perceptions of risk.

Host prevention strategies attempt to intervene at the level of the individual and are based on a number of considerations regarding individuals and their development. These attempts assume individuals are at risk of developing addictive behaviors because they have certain personality characteristics such as excessive shyness and early anti-social attitudes that increase their vulnerability (Apgar, 1998). Genetic factors are also believed to influence substance abuse in some individuals. Researchers (Authenelli & Schuckit, 1997) indicate *that children of parents with alcohol problems are significantly more* likely to develop problems with alcohol than children whose parents are not alcohol abusers. Recent brain research has demonstrated that vulnerability to addiction may have a genetic component and that addictive behaviors, such as eating and sexual behavior, stimulate the brain reward centers in similar ways as addictive drugs (Ibana & Cohen, 2000). Under host prevention strategies, considerations related to developmental issues are important in conceptualizing effective prevention. For example, an individual who is at risk for or who has already developed an addictive behavior pattern may not have successfully negotiated developmental tasks across the life span and, as a result, abuses substances to cope with these deficits. Thus, developmental efforts are designed to improve critical life and social skills, including decision making, refusal skills, and systematic and judgmental abilities.

Environmental prevention strategies address the many social and cultural factors which are influential in individual decisions regarding substance use and other potentially addictive behaviors. These factors may be viewed as contributing to the resiliency or the vulnerability of an individual or a community in relationship to drug use. These are factors characterized by interactions among family, school, peer group, and the broader community (Center for Substance Abuse Prevention, 1991). One such factor is the relationship of parental substance use to the onset of use among their children (Wills, Schreibman, Benson, & Vaccara, 1994). Another environmental variable is the role of the media and its substantial power to influence attitudes and behavior. Environmental prevention strategies provide for the participation of targeted populations in activities that exclude alcohol, tobacco, and other drug use by youth. Constructive and healthy activities are proposed to offset the attraction to or otherwise meet the needs usually filled by alcohol, tobacco, and other drug use. They also call for identification, education, and counseling for those youth who have indulged in inappropriate use of tobacco products or alcohol, or who have experimented with illicit drugs. Activities under these strategies would include screening for tendencies toward substance abuse and referral for preventive treatment for curbing such tendencies and then providing prevention and treatment services to individuals using alcohol, tobacco, and other drugs.

The agent, host, and environmental prevention strategies within the epidemiological model are addressed in the comprehensive prevention program recommended in this text.

Summary

This chapter provided introductory information defining and discussing substance abuse and prevention. A historical overview of substance abuse and its causation and prevalence was provided. Prevention was again defined, prevention models and strategies were discussed, and research support was identified.

Chapter Three

Prevention: The School Context

This chapter will outline the important role schools play in preventing substance abuse. It also will identify the changes in schools' practices that need to occur for effective prevention programming to be implemented. Historical influences and societal values are discussed in terms of their impact on a school's ability to address prevention.

Importance of the School in Substance Abuse Prevention

Schools are of central importance in our society, the stability of which depends on our ability to prepare well-adjusted, responsible, and well-educated young people. Our nation's continuing strength depends on schools, families, and communities to produce its future leaders and workers. To this end, communities must do more to confront and resolve social problems, families must provide sustenance, nurturance, and support, and schools must deliver appropriate and well-designed curricula in an environment that maximizes personal and cognitive development.

School is a powerful environmental influence in American society and the central and unifying force in many communities. Thus, it is logical that the school would be called upon to develop comprehensive prevention efforts designed to develop youth who have the personal strength and necessary skills to make healthy choices and avoid addictive behavior. Some type of prevention activity is on-going within every public school in the United States; however, it is obvious from the prevalence data on student use of drugs and other problems identified in Chapters One and Two that more comprehensive and impactful efforts need to be implemented.

Needed Change

In order to effectively implement prevention programs, several school-related areas requiring change will have to be addressed (Loftquist, 1989). As will be supported throughout this text, effective prevention requires more teachers who can facilitate not only cognitive but personal growth on the part of students. It also requires schools to be facilitative by providing improved environments where students can grow academically, socially, and personally at optimal levels. Who is responsible for developing facilitative teachers and facilitative schools?

Colleges of education have a major role to play. In reality, colleges of education and college of education professors are not doing their part. The lack of facilitative teachers can be traced to a lack of facilitative college professors, who to a large degree are wed to the formal lecture approach in their specialty area. In addition to serving as poor role models, their curriculum does not support the development of facilitative teachers (Witmer & Myrick, 1980). For years, academicians and teacher educators have argued about whether teachers-in-training should spend the majority of their time studying subject matter or studying educational methods. Unfortunately, both strategies teach cognitive development as unrelated to personal development and are not facilitative. This argument over strategies has occurred at the expense of studying needs of students and how to effectively relate to them.

To begin change, colleges of education must change. A commitment to true professional preparation with the end result being facilitative teachers must be made (Cobb, 1994). To do this, teacher educators will need to evaluate their own styles of teaching and demonstrate more concern for the personal development of teachers. Expanding human awareness and enhancing skill in interpersonal relationships must become an integral part of the college curriculum as well as that of schools. The challenge of building and developing new facilitative schools must be met and accepted by teachers of teachers (Witmer and Myrick, 1980). The reader is referred to Moore, et al (1991), for a suggested teacher education curriculum for preparing teachers in substance abuse education.

School districts also have a major role to play. Local school districts will have to accept more responsibility for improving teaching practices (Glasser, 1990). Fortunately, many teachers have developed facilitative skills in spite of their formal teacher preparation. However, there is overwhelming evidence that teachers are inadequately prepared for the interpersonal skill requirements of their teaching positions. Such evidence suggests there is a great need for school districts to provide communication skill development workshops that will help teachers to become more effective in their interpersonal relationships with students and other professionals (Sales, 1990c). School personnel responsible for in-service training must accept more responsibility in this area.

It is easy to accept the premise that faculty in colleges of education and people in authority in the school system should take responsibility for developing and fostering prevention programming, facilitative schools and facilitative teachers. It is more difficult to accept the reality that such change must begin with each of us if change is to occur. Individually, we cannot wait for others to begin. Rather, the process of developing facilitative schools must begin with each of us. In particular, it must begin with the individual school counselor. As concluded by Witmer and Myrick (1980), this process "...means having the courage to start again, to analyze our failures and disappointments, and then to move ahead. It means being patient with ourselves while we are learning to become more facilitative. But there can be no doubt, the responsibility is ours. It must begin with us. It must begin with you" (p. 203). Prior to beginning the process of developing facilitative schools, counselors, if they are not already aware, need to understand that the type, role, and effectiveness of school-based prevention activities are influenced greatly by the inter-relatedness of school context variables, the historical influences on schooling, the community support provided nationally and locally, the administrative leadership provided at the local level, and the resulting student and teacher climate.

The School Context

Historical Influences

Historically, public schooling in the United States has been influenced by two perceived needs, social and economic selection and personal development. By responding to the need of social and economic selection, schooling in America has attempted to ensure that America can meet the challenges of economic development by supplying business and industry with a trained workforce that can read, write, and calculate. In response to the need of personal development, schooling has placed emphasis on realizing the full potential of the child, providing a strong and liberal education, and developing a student's capacity to act thoughtfully (Berliner & Biddle, 1995).

The usual public judgment is that public schooling has responded more predominantly to the need of social and economic selection; however, most teachers do not agree. Teachers see themselves as taking great interest in the personal development of youth. Yet, research indicates this interest is often outweighed and negated by the structural properties of public schooling and its systemic practices. The structure, organization and bureaucracy, as well as schooling's practices of testing, evaluating, grading, grouping, and tracking have an impact well beyond that of the teacher.

Cynics agree that schools legitimize the status that children bring to school by putting the stamp of approval, acceptability, or competence on some, and not on others. No matter how valiantly teachers or others within schools may try to do this, schools, in general, do not alter the destinies that are set for their students as a result of race, gender, mother tongue, family situation, or family income. Children of racial and linguistic difference, especially those born and reared in poverty, are provided as much skill and understanding as possible before they drop out, get pushed out, or graduate with modest or poor academic records. Schools typically do not intervene to alter the predicted achievement levels or presumed performances of these students. Realities are that the efforts of individual teachers, most of whom care deeply about the students and are highly motivated to help them achieve, fall prey to their system requirements to test, mark, promote, group, evaluate, and grade students according to their capacity and performance.

Schools traditionally have reinforced the advantages children bring with them as a result of both their genetic and environmental circumstances. Since World War II, a general societal expectation has been for schooling to transform its role in reinforcing advantage to one of maximizing the talent available in society. One complicating factor in implementing this expectation over that time has been the changing nature of children who go to public schools. They are increasingly children who lack the advantages that good family incomes bring. They vary widely in cultural and linguistic background and in their attitudes about the value of school, home, community, and work. They are increasingly children who are the products of homes without the emotional support and adult attention so necessary for success in school (Fenstermacher, 1986).

Despite the recent emphasis of schooling to maximize the talent available in the population and respond to the changes in the nature of the children attending schools, schools themselves continue to be organized and run as they have been for over a century. The continuing need of social and economic selection dominates the structure and system of schooling while the response by teachers to the need of personal development leaves them desperately trying to succeed with all students. Resolving this dichotomy of needs will be difficult but necessary if we are to develop new schools whose systemic practices encourage maximizing talent. We must have schools that genuinely value and honor individual human difference - not just differences in ability, motivation, and attitude but differences in language, culture, and values. We must have schools that have school structures and school practices that maximize student talents. To improve effects, we must address and effectively change the broad structural, systemic, and individual practices of schooling. A strategy to begin this process is, as will be outlined in this text, to integrate effective comprehensive prevention efforts within schools.

Community Support

Even though improvements need to occur, the great American experiment in attempting to provide a quality public education for all has proven to be effective and representative of the best of democratic ideals. Schooling, however, is very easily targeted by politicians and other prominent individuals as a scapegoat to blame for perceived societal failures. Over the last few decades, reports have compared the scores of students in the United States and in other countries on tests in geography, spelling, math, and science. These reports consistently favor students in other countries, and related news reports consistently imply that the learning in United States schools is somehow not quite up to par. These comparisons suggest a view of learning that reduces cognition to an isolated and mechanical process (Commer, 1996). Within the last few years, a national example of support for this view of learning within schools has been the national political endorsement of testing as a measure of a school's success.

Most studies on schools measure effectiveness by students' performances on standardized achievement tests, specifically reading and math scores. Unfortunately, politically linking federal funds to achievement testing in schools is an extremely narrow view of learning. Other cognitive criteria, such as decision-making and critical thinking, are largely ignored (Adams & Hamm, 1994). Glasser (1990, p.428) states that "nothing of high quality, including schoolwork, can be measured by standardized, machine-scored tests." From this perspective, standardized tests may only provide a means of measuring low-quality work. Further, scores on standardized tests ignore and devalue high-quality work. Instruction is frequently test-driven, and learning for the sake of fostering and satisfying curiosity may be lost. A test-driven curriculum fails to meet the needs of youth and of society as a whole.

While our society endorses testing to "guarantee" learning within schools and endorses eliminating "failing" schools, it also devalues the teacher within the school. According to the Census Bureau (World Almanac Books, 2000), the median household income in 2000 in the United States was $42,100, regardless of education level. Yet, according to the American Federation of Teachers (2000), the average beginning teacher's salary for the 1999-2000 school year was $27,989. Our low teacher salaries reflect the general value society places on teachers' education and learning. Former Senator Dennis DeConcinni has quoted Albert Einstein: "A society that pays its teachers less than its plumbers will have neither good teachers nor good plumbers."

School funding provides further evidence of the lack of community support. During the decade of the 1980s, educational funding fell from 2.3% to 1.7% of the total federal budget. This decrease in funding has been accompanied by an increasing disparity between rich and poor schools. It documents the conditions of some American schools and highlights the disparity in school funding (Kozol, 1991). Both Kozol (1991) and Berliner and Biddle (1995) provide convincing evidence that some schools receive less funding per pupil than do other schools in the same city with these differences continuing to increase.

As was noted in Chapter 1, each year thousands of young lives are lost in that they are kept from attaining their potential and from contributing to society as a result of dropping out of school, aggressive behavior, teen pregnancy, suicide, and/or alcohol and substance abuse. This represents major personal and societal tragedies that can be prevented if resources were to be provided. However, society continues to pay more for treatment than prevention of these tragedies. It costs about $2,400 a year to send a child to school. But it costs $4,300 to support a family on welfare, and high school dropouts head more than half of those families. Taxpayers spend close to $14,000 a year to keep one prisoner in jail, and 62% of all prison inmates are dropouts (Inaba & Cohen, 2000). Any society that claims to be concerned with cost-effectiveness in its overall economy should direct resources toward more effective schooling and prevention.

Berlinder and Biddle (1995) suggest that education bashing reached its most comprehensive exposition in the 1983 *A Nation at Risk* publication of the National Commission on Excellence in Education. They also suggest this exposition was based on a political agenda rather than on evidence. In *The Manufactured Crisis*, Berliner and Biddle (1995) point out that public schools in the United States have done a marvelous job of educating American children. They also demonstrate that children actually know more than earlier generations, compare very favorably to students educated in other countries, and perform better than ever before. Additionally, teachers are better prepared than ever; however, it is clear that educators are stressed, distressed, and perhaps depressed as a result of a less than supportive national and community climate.

For education to succeed in general, and to help at-risk youth in particular, increased community and financial support is needed. Such support will not be forthcoming unless our society as a whole, both at home and in the larger community, gains a better understanding of the value of personal development related to learning (Commer, 1996). A more positive attitude about education and about teaching and resultant support will provide a basis for the development of more effective schools.

Administrative Leadership

The administrative leadership provided within each school district, and particularly that of the principal at the local school level, is critical to the success of schooling. The administrator's support and endorsement in maintaining or changing quality in education is required at the local level. This is particularly true in relation to implementing prevention programming. He/she can advance almost any agenda by providing appropriate supports and incentives. Simple verbal endorsement often sways action.

In relation to developing prevention programming, administrators must evaluate the learning environments - the systemic and structural aspects of their school environment - to identify and promote those aspects that are exemplary. They must also support and foster caring relationships between teachers and teachers and between teachers and students. Administrators need to look for and change those rules, routines, norms, and policies that keep teachers from connecting thoughtfully and powerfully with their students.

School Culture

One aspect of education that is linked directly to the success of the students is school culture. Every social organization has its unique culture, and schools are no exception. School culture is determined by student involvement, teacher factors, community support, curricular focus, and educational leadership. A culture provides its members with two things. First, it establishes a set of rules. Second, it enhances self-esteem through shared values, beliefs, rituals, and ceremonies. Students, faculty, and staff who take pride in their school culture are likely to work more effectively than those who do not (Moore, et al, 1991).

The culture of a school can be divided into two distinct portions: student climate and teacher/staff climate.

Student Climate

Student climate is, in part, a reflection of student's experiences with peers. Such experiences provide them with an opportunity to learn how to interact with others, develop age-relevant skills and interests, control their social behavior, and share their problems and feelings. As children get older, their peer group relationships increase in importance. The child's recognition that he or she belongs to a group is an important step in the development of identity. But belonging to a group has both benefits and costs in terms of the child's subsequent social development and behavior (Burns, 1994).

As children grow older, the importance of parents decreases as a reference group and as a model for conformity. Young people become very much more responsive to peer group input as measures of self-worth and self-esteem. The peer group represents the transfer vehicle for transition from childhood to adulthood and exemplifies the world outside the home. Traits such as compliance, aggression, leadership, and needs satisfaction are fine tuned within peer group interaction (Burt, Resnick, & Novick, 1998).

Students who succeed in school have both high expectations of themselves and a strong, positive sense of belonging to the school. They also are students who have the ability to make healthy choices among alternatives (Charney & Clayton, 1994), the ability to monitor their own behavior and progress (Shapiro & Cole, 1994), and the attitude of shared responsibility for learning (Cobb, 1994). Thus, students should be provided schools with a curriculum and extracurricular activities supportive of their taking responsibility for their own learning, monitoring their own progress, developing more positive self-esteem, solving problems, and making effective decisions. These personal skills support cognitive development and are preventative in terms of a wide range of problems confronting youth.

Teacher/Staff Climate

The working environment for teachers and other school employees is also part of school culture. Teachers' perceptions of their role, the degree of collegiality and collaboration among staff members, teacher autonomy, and the working environment help to make up the teacher climate of a school. One influence on teacher climate is the specific perception teachers have of their role and the way they play it out. Some teachers perceive their role as preparing students for higher education or employment. Some emphasize the fostering of skill in decision making, problem solving, and critical thinking (Adams & Hamm, 1994). Others see themselves as advisers who promote healthy social interaction and develop positive self-esteem (Commer, 1996). Regardless of how it is perceived, the role of the teacher is important to teacher climate, to the school's culture, and ultimately to students' success.

Several factors help enhance the schools' teacher climate. Consistent and focused meetings among teachers, psychologists, counselors, and social workers encourage stability, development, collaboration, and collegiality among the staff. When teachers identify themselves, and are identified by others, as professionals, the effect on teacher climate is positive. Administrative support which provides teachers with the power to make sound educational decisions encourages them to converse with one another in their professional language and allows for a collegial and collaborative interaction within the school. This teacher interaction, in turn, will enhance the educational environment for all students (Witmer & Myrick, 1980). Most teachers work hard, are concerned about children, and try to do a good job of teaching. Teachers know that all children need support, care, and nurturing. They also know that the support and care children receive at school is particularly critical, given the pressures facing parents and the increasing fragmentation of neighborhoods and communities.

The teacher climate must be characterized by empowerment of both teachers and students for effective prevention to occur. Empowerment is "the process by which people, organizations, or groups who are powerless or marginalized (a) become aware of the power dynamics at work in their life context, (b) develop the skills and capacity for gaining some reasonable control over their lives, (c) which they exercise, (d) without infringing on the rights of others, and (e) which coincides with actively supporting the empowerment of others in their community" (McWhirter, et al, 1998, p. 12). Empowerment helps teachers and students to actively confront their environment rather than passively accept their conditions as unalterable (McWhirter, et al, 1998).

Three important aspects of empowerment, power analysis, skill development, and exercising new choices and behaviors, should be reflected within the teacher climate and teaching strategies. The teacher climate should help students understand power analysis and how they are influenced by others. When students are allowed to explore their situation in a nonjudgmental atmosphere, they have a basis for choosing different attitudes and behaviors. This process is termed "power analysis" and can be integrated into a variety of standard subjects, such as history, language arts, government, creative writing, and literature. Power analysis can focus on family dynamics, school and community factors, and local and national government policies; it can also be applied to racism, sexism, ageism, ecology, nuclear weapons, and a multitude of other topics. The key is to help students understand how these issues affect them as individuals.

The development of skills necessary for responsible choices is also a key ingredient of empowerment and effective prevention programs. Helping students learn more effective social skills increases their power over their personal environment (Burns, 1994). Learning cognitive-behavioral skills helps them control and cope better with their internal processes. Providing them with learning strategies facilitates their intellectual growth. Decision-making and assertiveness training, imagery and relaxation techniques, and other psychological tools enhance their ability to cope effectively with their environment. Training in other skills, such as research, writing, organizing meetings, public speaking, and leadership, enables youth to take more active roles in confronting or joining various power structures influential in their lives. Empowerment suggests that, although problems are often rooted in systems, individuals can and must share the responsibility for addressing and alleviating the problems. Providing a teacher climate that assists students in identifying new choices and behaviors is essential, as is providing students with opportunities to practice those behaviors and actively pursue those choices (McWhirter, et al, 1998).

Teacher influences on and within the working environment also are important (Adams, 1969) and warrant a brief discussion here. These include the teacher's impact on the structure of the classroom and curriculum and the importance of smaller class sizes. Classroom structure can affect the self-esteem of students. An environment in which students are treated as unique individuals who have a unique contribution to make to the group yields positive results (Elmore, Peterson, & McCarthey, 1996). Such an environment produces an acceptance of and appreciation for differences, an increase in creativity, an enhancement of personal autonomy, and an improvement in mental health and the ultimate overall quality of learning (Witmer & Myrick, 1980).

Observations and reviews of schooling conclude that much of the school day is spent by students learning facts and developing isolated skills. Students have little enthusiasm for this type of curriculum and over time become passive players in the schooling process, doing little but what they are required to do. Further, controversial and sometimes very interesting content areas are being omitted from the curriculum (Glasser, 1990). Educators agree that it is their responsibility, as well as the parents', to pass down the common values of society (Adams & Hamm, 1994; Wilson, 1993). Yet, anything associated with "values clarification," "values education," or "morals" sets off alarm bells in some segments of the community. Many districts tightly regulate classroom discussion of topics such as sexual behavior, suicide, substance abuse, and pregnancy prevention in an effort to avoid controversy. A curriculum that hinders or ignores moral education, development of social skills, student dialogue, and critical thinking invites boredom and dependence, limits students' goals and decision-making capabilities and does little to help students. The curriculum must be flexible enough to adapt to the needs of students, and teachers must be free to discuss current issues pertinent to their students' lives, including sex, drug use, suicide, pregnancy prevention, and AIDS.

In addition to teacher and curriculum influences, researchers (Berliner & Biddle, 1995) have found academic achievement to be related to class size. They now advocate smaller, heterogeneous groups that work cooperatively within the classroom in lieu of homogeneous ability groups (Sharan, 1994; Slavin, Karweit, & Wasik, 1994). When teachers and students are provided the opportunity through smaller classes to work more collaboratively, there is a positive effect in the overall school environment (Reminger, Hidi, & Krapp, 1992).

Summary

This chapter reviewed the importance of schools for prevention, needed change to implement prevention, historical influences, and societal values placed on schooling in our society. It also identified a variety of attitudinal, procedural, and structural changes necessary to improve learning in schools. These changes need to be addressed by school counselors in effectively implementing a comprehensive prevention program.

With so many young people at risk and not doing well, it is logical that schools would be called upon to develop comprehensive prevention programs. To have a preventive effect, there is more to schooling and teaching than simply dispensing academic content or skill. Obvious benefits exist when teachers have content and skill to share, but the most important prevention consideration is how schooling is delivered and how teachers teach. What teachers should be seeking to do is to enlighten, empower, and emancipate the mind of the learner. To do so, they must demonstrate certain kinds of human conduct that respects, values, and supports students and allows them to develop self-responsibility and to feel powerful and in control (Witmer & Myrick, 1980). By demonstrating these skills, teachers are able to form human relationships with students that are grounded in caring and that are empowering. These skills provide the teachers with the ability to develop learning environments that enhance student opportunities for self-esteem, personal power and mastery, autonomy, and enlightenment.

Prevention programming supports the view that adequate learning is comprehensive. Teaching approaches, practices, and adopted curriculum should emphasize the entirety of students' learning and development rather than just isolated mechanical functions. Teachers must provide a positive teaching climate with curriculum and classroom support for personal as well as cognitive development of students. Collegial support and collaborative decision making among teachers within schools can improve school climate and resultant learning. School philosophies and practices that encourage student empowerment and related prevention efforts should be promoted. By helping students learn to approach their work and their interactions with others positively, teachers can help students learn to live their lives more collaboratively. Students must learn to see themselves as having the ability to take control. Schooling must help them begin by looking at themselves as decision-makers rather than passive containers to be filled with knowledge.

Effective prevention programming requires administrative support, facilitative teachers, appropriate curriculum, extracurricular activities, and family and community support. All of these, as you will see in Chapter Four, are critical components of an effective comprehensive prevention effort within the school. Insuring the implementation of all of these components into a comprehensive prevention program is the responsibility of the school counselor. No other school practitioner is better prepared or positioned to implement prevention efforts successfully within schools.

Chapter Four

The Comprehensive School Prevention Program

The comprehensive school prevention program outlined in this chapter addresses components within the school that can be supportive of prevention - a prevention curriculum, teacher knowledge and skills, school climate including policies and procedures, and family and community support. To be effective, multiple prevention strategies must be implemented across these components. The most successful school prevention programs utilize a team approach with the school administrator, the classroom teacher, and the guidance or school counselor as the primary members. Auxiliary members include all school personnel, parents, and community representatives.

The school administrators must take responsibility for endorsing and supporting the implementation of prevention programming. Initially, they must foster interest in the program by bringing the issue to the attention of the community. They must be able to promote a program with realistic goals and able to gain commitments for support from those who have approval and funding power. They also must be able to identify and coordinate the efforts of community resources that may help the program. Many individuals and groups in the community (e.g., physicians, nurses, clergy, law enforcement personnel, drug rehabilitators, former drug abusers) are willing and able to support the prevention efforts of the school.

In the substance abuse prevention arena, teachers are considered to be in the most important role as prevention agents. Most teachers are not prepared to take on this role. Many view it as an additional duty. Some reject it outright.

When presented with rationale for prevention, most teachers will be flexible in meeting the challenges of the expanded role of schools today. Most are committed to being reflective practitioners who demonstrate warmth, empathy, and encouragement to all types of students. Teachers will choose the role in prevention with which they feel most comfortable. Whatever the role, teacher attitudes and practices concerning substance use will be observed, challenged, and/or emulated by their students.

Every teacher, regardless of teaching assignment, plays a role in a school's prevention efforts through his/her teaching and interactions with students. Teachers can individually and collaboratively determine for themselves the appropriate scope and sequence for prevention education and choose concepts and methods that best complement their courses and students. The challenge for all teachers is that of creatively integrating drug prevention education into the curriculum while continuing to meet content requirements mandated by state guidelines. Many prevention curricula offer suggestions for integration which free the teacher from additional planning while providing for personal growth and development and a strong, consistent message about the dangers of drug use. This integration approach is most successful when it occurs in the context of school-wide commitment.

The school counselor's role is fully addressed in Chapter Five, where this author's belief is presented that the school counselor is in the best position to serve in a leadership role as the initiator, coordinator, and director in implementing and sustaining the school's comprehensive prevention program.

The school counselor provides major input into and training support related to implementing the curriculum's primary prevention efforts. The school counselor can coordinate the activities of the curriculum development team and conduct related in-service programs for teachers. The counselor has responsibilities at all levels of prevention in schools. Primary prevention emphasis is on climate and curriculum. Secondary and tertiary prevention emphases are on extra-curricular activities that have historically been more closely identified as counseling and guidance. These also include sponsoring auxiliary programs such as student peer groups, peer court, or hot lines, and serving as liaison with parents. By supporting a school's comprehensive prevention program and serving as a role model, the school counselor reinforces for students the idea that a drug-free lifestyle is of paramount importance.

It is important that prevention activities be coordinated on a school-wide basis. No prevention curriculum can have much impact on student behavior unless it is delivered within the framework of a comprehensive prevention program that encompasses school instruction, guidance services, student activities, parent involvement, and community support.

Prevention Curriculum (K - 12)

Simple knowledge about drugs does not deter their use. Thus, information alone does not equate to prevention. Educational strategies must address needs of students at all age levels and all levels of potential drug use. Thus, the educational component of the program must be taught at all grade levels (K-12), both as a specific sequential curriculum and as an integrated part of existing courses. Prevention curricula can be purchased as a package, created by a school, or adapted from other existing materials to meet a school's individual needs. They are most effective when they are integrated into other subjects in the existing curriculum and address knowledge as well as skill development. Prevention curricula information about alcohol, tobacco and drugs must be current, supported by relevant and up-to-date materials, and focused on health and wellness with an emphasis on personal and social responsibility for one's actions (Jessor, 1993). Research reviews indicate a curriculum designed to promote life skills such as stress management, refusal skills, and communication skills will be effective in preventing the abuse of alcohol and other drugs. One example is a life-skills training program developed by Gilbert Botvin (Botvin & Golona, 1997). Its goal is to facilitate the acquisition or improvement of basic skills needed to prepare individuals to confront social influences that promote heavy alcohol consumption and other drug use. Life-skills training builds personal competence, helps youth cope more effectively with certain tasks, enhances self-concept, and improves problem-solving ability. In studies related to this training, one year after the program's conclusion, the incidence of smoking among its participants was 50 % less than among those in a comparison control group (Botvin & Golona, 1997).

In general, research indicates that the most effective prevention curricula are those that build personal competence through cognitive and affective education tasks that focus on increasing personal growth and increasing experiential learning (Moore, et al, 1991). Most authors agree that a prevention curriculum should broadly address communication, behavioral skills and psychological competence.

Communication Skills

Communication skills, knowledge, and techniques are taught within the curriculum to improve the listening, responding, and interpersonal skills of individuals. The curriculum addresses individual behavior change in communication skills, social and assertiveness skills, decision making, and anxiety reduction activities. Learning verbal and nonverbal communication, how to avoid misunderstandings, and how to create healthy friendships and love relationships are components of most curricular programs promoting communication skills.

Behavioral Skills

Behavioral skills target prevention of stress with special attention given to such techniques as training for assertiveness, social problem solving, cognitive restructuring, meditation, and progressive muscle relaxation. These approaches are included in the curriculum and in extracurricular activities.

Assertiveness and resistance/refusal skills are behavioral skills that are interrelated with communication skills and critical to prevention. Assertiveness skills training involves actually saying what one wants to say with congruence between thoughts, verbal messages, body language, and behavior. Resistance/refusal skills (the ability to avoid experimentation) are taught based on social inoculation theory, which, in turn, is based on the premise that developing arguments in advance helps prepare people to face actual situations. Emphasis is on increased awareness of social influence on using drugs, attitude reinforcement, behavioral rehearsal (role-playing), and public commitment (behavioral contract) on how to resist peers and refrain from use of alcohol or other drugs.

Behavioral skills related to handling conflict are particularly important to substance abuse prevention. Conflicts are common in any group and present a necessary and creative dynamic in most relationships. Conflict in itself has some positive outcomes such as encouraging self-examination, providing alternatives, and promoting growth and change. Negative styles that individuals and groups use to resolve their conflicts include avoiding, withdrawing from the conflict situation, forcing one side to give in, and giving in without confronting areas of disagreement. Positive approaches, such as compromising and problem-solving, in which the parties bargain to receive part of what they desire, are preferable and can be taught in the classroom and through peer mediation.

Research continues to support the fact that stress is a significant contributor to substance abuse. Therefore, stress-management and positive, active coping skills such as self-regulation and management of positive emotions are necessary to counter reactive coping skills. These skills, as well as relaxation techniques, are taught in an effective prevention curriculum.

Psychological Competence

Competence in youth is addressed in the K - 12 curriculum through individual and group training. Emphasis in this area is often identified as psychological education. Goals range from improved understanding of self to improved understanding of others through increasing greater cognitive knowledge of and skills in interpersonal principles. The emphasis is consistent with areas addressed in career education, one of the original bases of the vocational guidance movement. One aspect of competence is peer selection, the ability to establish and maintain friendships that reinforce positive health and interpersonal beliefs and practices. This is taught in the classroom curriculum as well as integrated into extracurricular activities through peer leadership/ education programs. Competence in youth is addressed individually by the counselor and in the curriculum through teaching problem solving, decision-making, critical thinking, self talk and awareness, values clarification, and goal setting.

(1) Problem-solving is viewed as a prerequisite for human survival (Rowe,1985) and involves analyzing and resolving a range of problems from minor ones to perplexing or difficult situations. Research indicates early instruction in social problem-solving averts subsequent problem behaviors. Problem-solving skills contribute to the development of an internal locus of control, which in turn builds a sense of self-efficacy and self-esteem and strengthens resistance to substance abuse and other problem behaviors.

2) Decision-making involves selecting from alternatives a model to state the goal, generate ideas, prepare a plan, and take action. Each of the operations requires a decision, and, in each, the decision-making identifies problems (analysis), creates options (synthesis), and makes a decision based on evaluation.

(3) Critical thinking is characterized by reasonable, reflective thinking that is focused on deciding what to believe or do. The goal of teaching critical thinking is to develop students who are objective, look at all alternatives, and are committed to getting the facts before taking action.

(4) Self-talk refers to the cognitive process of inner dialogue which guides behavior. Within classroom curriculum activities, students can learn to use self-talk in positive ways that incorporate many life skills such as critical thinking, problem-solving, decision-making, peer selection, and stress reduction. Self-talk is central to behavioral self-control.

(5) Self-awareness and valuing for the concepts of wellness and self-care provide the foundation for personal responsibility--the perspective of an individual who recognizes that he or she has the power to control his or her own thoughts, emotions, and behaviors in life. Students and teachers alike need encouragement to be more caring and responsible for their own health and well-being, especially when the social environment promotes irresponsible or non-healthy behavior.

(6) Values-clarification involves a series of strategies or methods for assisting a student or students to clarify values. Values are defined as those prized beliefs, purposes and attitudes that are chosen freely and thoughtfully and give direction to life. Values-clarification exercises help students realize that how one chooses to live one's life and how and where one chooses to seek experiences and meaning are important. Steps in values-clarification are encouraging students to make choices and to make them consciously, helping them discover and examine available alternatives when confronted with choices, assisting

students in weighing alternatives carefully by reflecting on the consequences of each, urging students to contemplate what it is they prize and cherish, providing opportunities for students to make public affirmations of their choices, encouraging students to act and live in accordance with their choices, and helping them examine repeated behaviors or patterns in their lives.

(7) Goals provide self-motivation against which an individual can measure and regulate. The process of goal setting involves clarifying and finding ways to get what one wants or needs.

As indicated, the above curriculum areas are generally agreed upon as required within a primary prevention curriculum. In addition, a prevention curriculum should encourage *interactive learning* in which students participate in their own learning rather than sit idly and listen to a lecturing adult (Moore, et al, 1991). Development of self-awareness and positive self-esteem are critical components of the curriculum. Other emphasis areas are establishing positive peer adult relationships and developing enlightened consumer awareness to be aware and critical of media and societal messages promoting drug use. In support of this curriculum, secondary prevention efforts such as peer counseling and student assistance programs, and tertiary prevention efforts such as guidance activities which include individual and group counseling need to exist.

A curriculum that promotes and develops the above life skills —social competence, peer selection, problem-solving, decision-making, critical thinking, stress reduction, self-talk, wellness, conflict resolution, values-clarification, and goal setting—is one major component of the comprehensive school prevention program. The second major component is the teacher knowledge and skill required to deliver the curriculum in a facilitative manner (Moore, et al, 1991; Witmer & Myrick, 1980).

Teacher's Knowledge and Skills

Research reviews and empirical studies have identified the teacher knowledge and skills that are related to substance abuse prevention (Jones, et al, 1990). Teacher knowledge needs relate to substances, curriculum and prevention, information and referral, health, human behavior, and legal issues. This knowledge is needed to effectively convey the content identified in the previous curriculum discussion. Teacher-student relation skills are viewed as critical to the success of prevention efforts in schools (Jones, et al, 1990; Witmer & Myrick, 1980). These skills are characterized by being accepting of self and others, communicating effectively, having good listening skills, varying learning opportunities for students' cognitive, social and emotional development, and serving as a role model. The facilitative teacher is attentive, genuine, understanding, respectful, knowledgeable, and communicative. He/she is able to facilitate personal as well as cognitive growth of students (Witmer & Myrick, 1980)

Teacher as Facilitator

The skills of the teacher as facilitator are critical to being able to deliver a prevention curriculum (Jones, et al, 1990). The teacher's ultimate goal is to facilitate a process to help students maximize their potential and opportunity (Witmer & Myrick, 1980). Ideally, teachers can support prevention of substance abuse by gaining student trust and respect. One way of doing this is to develop classroom management skills and interpersonal relations skills that have been shown to enhance student achievement and self-concept (Charney & Clayton, 1994). The way a teacher behaves, not what he/she knows, may be the most important issue in the transmission of the teaching-learning exchange (Witmer & Myrick, 1980). Through example, teachers can and must be catalysts of attitudinal as well as behavioral change. The extent to which a teacher becomes personally involved with students and creates a positive social climate reinforces student interest and student motivation in emulating the teacher. The major contributions of the teacher to primary prevention relate not only to his/her knowledge but also to his/her student relationship skills. To be prevention agents, teachers must be able to effectively deliver a prevention curriculum and provide high levels of understanding and respect in their relationships with students.

Witmer & Myrick's (1980) text identifies "good" teachers as accepting, stimulating, and encouraging and "poor" teachers as impatient, remote, rejecting, and cold. They found that the quality of the teacher's relating to the child was perhaps the most important basis for the learning attitude of the child. Academic and clinical experts in the substance abuse prevention field have identified teacher characteristics and competencies that contribute to teacher-student relations as the most beneficial factors in preventing substance abuse among students. These teacher characteristics and competencies include genuineness, effective communication, rapport with students, honesty, congruency, mutual respect, ability to listen, ability to develop trust, being an effective role model, and congruency (Jones, et al, 1990). As noted earlier, Witmer & Myrick (1980) well document that the teacher's ability to function at high levels of positive regard, genuineness, and empathy is related to positive personal and cognitive development of students. Interpersonal relationships are at the heart of education.

Learning Environment

The teacher's role as a model provides a standard for relating to others in genuine and respectful ways that students can emulate. When played out in the classroom, this role supports student development of effective communication skills.

Structuring the classroom to promote the development of life skills such as communication depends on the teacher's ability to establish a positive, supportive classroom environment (Witmer & Myrick, 1980). Person-to-person contact and interaction are central to creating a healthy psychological climate. The ground rules of communication, however complex in interaction, are simple. Each person must commit to an open, non-repressive form of communication in which participants are regarded as human beings, they are valued and nurtured constructively by one another, and trust, safety, cooperation, and support flourish (Witmer & Myrick, 1980). Methods teachers can use to accomplish and maintain effective communication include; cooperative learning practices, classroom instruction incorporating peer-education techniques, and modeling and promotion of positive behaviors, attitudes, and life skills by the teacher. All of these methods should be addressed in age-level appropriate learning experiences within effective K–12 prevention curricula.

Communication is a basic life skill; it is an expression of self and a way of learning about others. Effective communication is characterized by observation, listening, empathy, self-disclosure, giving and receiving feedback, genuineness, and respect. Students and teachers alike take note of behavior and activities within the classroom. They then draw conclusions from these observations and often act on these interpretations. Sometimes one person's interpretations do not accurately reflect another's behaviors. What is noted and the inferences made often say more about the observer than the person being observed. It is imperative that teachers understand the process by which they observe and infer as well as recognize the importance of examining their impressions before acting on them.

Listening may be the most important factor in effective communication; its goal is understanding. Through listening, one is able to begin to relate to another's point of view and to understand how that person may be feeling. Active listening indicates interest in the speaker, builds rapport, helps to prevent misunderstanding and is characterized by attending with one's body, paying attention with one's language, and not interrupting.

Empathy is the skill of being able to understand and identify another's feelings and situation and convey this understanding back to others. Empathy can be demonstrated by paraphrasing, when you use your own words to restate what another has said, or summarizing, when you verbally sum up several ideas and feelings that have been conveyed. Using these skills shows that teachers have been listening and are trying to understand.

Self-disclosure is the process of letting others know more about you by sharing what you feel and think. When the teacher models self-disclosure, students are encouraged to be more open. In using self-disclosure, it is important to consider the appropriateness and timeliness of the message. It is not appropriate for teachers to share aspects of their personal lives. Appropriate disclosure is the sharing of thoughts and feelings in the moment that relate to the shared experiences in the classroom. This brings honesty and authenticity to the student-teacher relationship. A related consideration is the use of "I" statements. When one uses an "I" followed by his or her own feelings or thoughts, it indicates ownership. In prevention, "I" statements become particularly powerful in that they reinforce through language personal responsibility for thoughts, feelings, and behaviors.

Giving and receiving feedback is a way of learning more about ourselves and others. Feedback is most helpful when it describes a specific behavior and considers the needs of the receiver. It is most useful when it focuses on one thing at a time and involves observation of a behavior that can be changed rather than expressing reactions to a whole string of behaviors. Providing feedback as soon as possible after the behavior occurs increases its potency. Effective exchange of feedback can only occur when teachers establish classroom environments that are non-judgmental and supportive.

Teachers demonstrate genuineness when their verbal communication is consistent with their non-verbal behavior. They demonstrate respect in a number of ways such as acknowledging and accepting differences, not giving advice, not interrupting, and not attempting to solve others' problems. Teachers who are respectful allow their students to develop their own solutions.

As can be seen from the above discussion, communication involves the expression of both content and feelings. When working in a preventative way with students in the classroom, teachers need to integrate all of the above skills with a focus on the group. Through observation, listening, clarifying, summarizing, self-disclosing, giving and receiving feedback, and demonstrating genuineness and respect, the teacher attempts to involve students in meaningful interactions that assist them to understand themselves and others on a deeper level. This understanding is critical in the process of students developing life skills that support healthy living. The teacher's role, no matter what the curriculum emphasis, is to make sure classroom interactions contribute to the personal and cognitive development of all students.

Empowering Versus Enabling

While the meaning of enabling and empowering appear similar, enabling has taken on a very negative connotation in the field of alcohol and drug abuse prevention. Enabling is reviewed as rescuing. It results from a system of beliefs, attitudes, and behaviors that unwittingly allows individuals to abuse alcohol or other drugs and to continue to do so by preventing the abuser from experiencing the consequences of his or her condition. Enabling usually occurs under the guise of love and concern or is prompted by guilt or fear. It reinforces a person's denial of a problem with substance abuse. In contrast, empowering involves reinforcing appropriate, healthy behaviors and discouraging those that are not in the best interests of the person or society. It includes the concept of building personal and interpersonal skills. It also includes the development of life skills such as communication, critical thinking, problem-solving, and decision-making.

Some teachers enable unhealthy behavior by not knowing what behaviors are associated with risk for substance abuse and other problems. Other teachers, who are familiar with risk factors, enable by overlooking negative behaviors, being afraid to take action for fear of reprisal, and being afraid that students will not like them if they take action (Moore, et al, 1991).

Teachers automatically support empowerment by modeling how they want children to behave. They are facilitative in their interaction with students. They provide opportunities for children to learn healthy ways to solve problems, make decisions, develop social skills, express themselves, and manage stress. They value each child and provide extra support when necessary. They maintain routine and stability in the classroom, keep expectations high for each child, and provide age-appropriate and accurate information about alcohol/drug abuse and other problems that may be impacting student lives (Brown, 1999).

Teaching Methods

The teaching methods that facilitate learning range from the didactic to the experiential. The didactic method is characterized predominantly by talking or lecturing by a teacher. Student involvement is characterized by listening, memorizing, and feeding back content. It involves little feeling or emotion in the student, may have little relevance, and may hinder personal growth. The experiential method is characterized by the teacher facilitating personal involvement and meaning. Students knowledge is gained through their own actions, practices, and perceptions and by having experiences and talking about them. Personal learning occurs when subject matter is seen as having relevance for one's own purposes. Both the didactic and the experiential methods have value; however, an effective teacher should be able to vary teaching methods to keep students engaged in learning. Experiential methods are needed to effectively address the major components of a prevention curriculum such as decision-making, resiliency, self-esteem, self-responsibility, ability to deal with stress, social skills training, and assertiveness training.

While mastering the process of learning is a modern concept, the belief that active learning is more powerful than passive learning was first emphasized by John Dewey. Recognizing that learning is a process that requires an openness to experience and personal involvement is an important first step for teachers in helping students learn more effectively and efficiently. Learning is self-initiated, self-evaluated, and feeling-focused. It is facilitated through open communication when teachers' feelings and student's feelings are valued, shared, discussed, and related to intellectual concepts and plans.

School Climate

The third major component of a comprehensive alcohol prevention program relates to the school climate. To be supportive of prevention efforts, the school climate should reflect an anti-drug message throughout curricular and extracurricular activities that links consequences—rewards or punishments—with behavior. It should also be an environment supporting a sense of belonging for all students, the promotion of an appreciation of self and others, and a cooperative atmosphere throughout the school. This climate can be achieved by involving students, teachers, and staff in collaboratively defining and solving problems; holding recognition programs for students, teachers, and staff; promoting school spirit through a variety of student activities; and encouraging parental support and involvement. To establish the norm of a drug-free school, supervised drug-free social activities and alternatives must be provided. An effective program provides students experiences outside of class that support prevention such as drug-free activities and expectations and assists all students in successfully integrating into the school environment.

In anti-drug school climates, school counselors have provided individual resistance training combined with training in decision making, interpersonal communications and self-control skills to diminish the power of social influences on the decision to use drugs (Lane & McWhirter, 1996). Other supports in a school anti-drug climate include peer leaders/educators who are students selected and trained to serve as positive role models and to provide social information that reinforces factual information about substance abuse (Hansen & Graham, 1993). Peer educators teach social skills to resist pressure to use or try drugs and help students identify and practice enhancing alternatives to drug use.

Clear Policies and Procedures

Most school districts are required by law to have written policies on substance use. Effective prevention programs also require written policies. The most effective policies are those developed in consultation with students, district personnel, parents, law enforcement officers, and other members of the community. A critical need related to policies is a clear articulation of procedures to follow in relation to each. There are three important steps necessary once policies and procedures have been written and implemented: (1) communication about them with students, parents, and staff; (2) equal and consistent enforcement; and (3) ongoing evaluation of their effectiveness. As indicated before, in order for policies to be effective, procedures in implementing the policies need to be clearly identified and articulated.

A policy, in practice and in fact, is a legal document that defines due process for students, staff, and parents in relation to how the school will handle issues or problems related to the use of alcohol and other drugs. Policies should be based on a philosophy statement developed after thorough discussion of beliefs and values regarding a specific drug and related problems on which a specific policy is based. The statement should define the school's role in attempting to help students resolve the problem. The policy statement lists ways in which the school system will act in various situations such as possession, sale, or use of tobacco, alcohol, or illegal drugs. A policy usually states that, if "something" occurs, then the school will have to do "something." Procedures or actions which will be taken in specific situations need to be clearly defined for students, staff, and family. Effective policies and procedures need to be clear and concise and printed for distribution campus-wide and to parents. The procedures should provide for consistent, fair, and immediate attention to and enforcement of violations. Philosophical statements and related policies and procedures should be reviewed yearly.

Input into and participation in developing policies and procedures should come from as many of the key school and community prevention partners as possible. The Prevention Impact Team (to be discussed in Chapter 7), comprised of representatives from teachers, counselors, parents, and community, should determine the essential components of policies and procedures. Specific activities to be addressed include the following:

- developing a position statement regarding use of tobacco, alcohol, and other drugs by students, staff, and visitors on school property;

- identifying the steps to be pursued for first, second, and third offenses if an individual is found under the influence or in possession of any drugs on the school property;
- determining and developing a formal memorandum of understanding with local law enforcement agencies regarding the role and responsibility of law enforcement on the school property;
- insuring policies and procedures are consistent with the school district's position on staff drug use, employee assistance programs and state laws;
- defining a process for involving or informing parents when offspring have violated a policy; and
- determining the amount of school assistance that will be provided to students when seeking assistance with a substance abuse problem.

Policies and procedures should comprehensively address the above and reflect a school's unique needs.

Prevention Programming

Literally thousands of prevention programs have been designed to meet the extra-curricular needs of students. Successful programs have several features in common such as small size, inclusion by choice, and flexibility.

Intervention programs at the elementary level focus on consistent and effective communication with families. Services include parent training and providing a link between the school, the home, and the larger community for family counseling and other services as needed. Prevention programs of middle schools are designed to meet the needs of students who are maturing at widely varying rates. Counselors need to develop programs in middle schools that serve as a transition from the elementary school to the high school. They need to coordinate the efforts of the school and the family. The parent training programs play a very prominent role for middle school counselors.

Many prevention interventions at the junior high and high school level focus on ways to get students through school. Most emphasize support systems designed to help students overcome obstacles, such as poverty or large class size, and accumulate credits. Their ultimate goal is to increase the graduation rate of students. Most of these approaches are directly related to the school dropout problem.

At the secondary level, intervention programs focus on alterable school conditions. They emphasize flexibility in regard to course requirements and grading systems, support from teachers and administrators, teacher-student contact strategies and instructional approaches, as well as provisions for supportive vocational and school community educational programs (Cohen & de Bettencourt, 1991). School counselors and psychologists in particular need to develop and implement training in life skills that specific young people need. School mediation programs (Lane & McWhirter, 1996), peer and cross-age tutoring and peer facilitation/leadership programs (Tansey, de Barona, McWhirter, & Herrmann, 1996), small-group counseling, and coordination with community agencies and support programs for specialized treatment, job training, and mentorship are extremely important for intervention at the secondary level.

Student Assistant Programs (SAPs) provide unique service programming at the secondary level in support of school-based prevention efforts and are often written into most policies and procedures as a referral option. These programs are particularly needed when students begin to experiment with alcohol and other drugs in the primary grades. The ability to have early intervention, identification, and referral of students for counseling and treatment services of SAPs is important to the school's overall prevention effort. SAPs usually involve utilizing services of community members and agencies, school counseling programs, and student support groups, student peer counseling, and possibly on-site programs such as Alcoholics Anonymous, Overeaters Anonymous, and Alateen (Erhard, 1999). Peer-led prevention efforts are perceived by students as more effective than are adult-led efforts. Model drug-use policies and procedures in schools include a blend of strict enforcement and supportive help for anyone violating a policy. By way of example, a first time offender using alcohol or other drugs on the school campus may be given a choice in the school's policy statement between a time-related school suspension or a shortened or in-house suspension with the option of participating in SAP support groups. Care must be taken to ensure that students' rights to due process are protected. To this end, procedures must detail the exact steps and options to be followed by staff. When and how parents and police are to be contacted and who contacts them must be clearly specified.

SAPs target not only substance abuse problems, but also any problems interfering with personal or educational development. Various types of SAP support groups include those targeting:

- insight or assessment for students who may be experiencing problems and need to examine their use of alcohol or other drugs;
- concern for others such as children, siblings, significant others, or friends of substance abusers; and
- sharing other concerns not related to substance abuse such as death, divorce, abuse, neglect, teen pregnancy, or parenthood.

Family and Community Support

The fourth major component of a comprehensive prevention program is family and community support. A campaign to inform parents of school based-prevention efforts is a must. Targeting involvement and support of parents and community is essential to the success of any school-based prevention program. Such involvement provides a means for parents to become informed about alcohol and other drugs, including patterns of use at various ages. Through development of a parent/community advisory committee, goals and objectives for parental involvement can be individualized for the school, and community resources can be tapped to facilitate ongoing programs. Parents, local employers, community partners, and other volunteers recognize society's stake in and responsibility for successful schooling. A very high percentage of them view substance abuse as the major problem within our society. They actively participate in program implementation as volunteer speakers or other supporters, as partners in working with their children in educational and career planning, and as referral sources in helping other parents with answers and support and helping children obtain special services. They serve on the parent/community advisory committee and participate in review of prevention materials and prevention program design. Their involvement generates a better understanding of the role of prevention and guidance in schools and a needed political resource of knowledgeable supporters (Burt, Resnick, & Novick, 1998; Gysbers & Henderson, 2000).

Family and community support of a school's prevention efforts can also help battle the negative impact of the mass media. Media is a powerful source of influence shaping attitudes, beliefs, norms, and behaviors. Social commentators have criticized its role in promoting tobacco, alcohol, and drug use, particularly the pervasiveness of drug content in movies, television and radio shows, magazines, and music. Media literacy is a goal of numerous prevention programs (Hansen & Graham, 1993). Family and community support groups, to some degree, can attempt to counter the negative impact of media through support of public service announcements (PSAs). However, the impact of PSAs is characterized as infinitesimal compared with advertisements promoting tobacco, alcohol, and drug products; and, in many ways, PSAs fail to reach the intended audience. To have more impact, PSAs must be aired during "prime time," and place greater emphasis on strategies designed to combat the powerful social influences to smoke, drink, or use drugs.

Join Together has issued a report on how communities can develop strategies to fight drug abuse and has provided a technical assistance packet (Join Together, 2000b) to help communicate these strategies. Melton, Chino, May, and Gossage (2000) also offers useful promising practices and strategies for reducing alcohol and substance abuse aimed specifically at American Indians and Alaska natives.

The family is perhaps the most significant environmental influence. Young people who feel connected to their families and school are less likely to use cigarettes, alcohol, and marijuana. To a lesser degree, young people who have parents with high expectations, parental presence in the home at critical times, and involvement in shared parent-child activities are less likely to use drugs and alcohol (Resnick, 1997). Parent and family skills training, in-home support services, and family therapy have demonstrated great potential for prevention success (Hogue, Liddle, Becker, & Johnson-Leckrone, 2002). Parent and family skills are designed to improve poor parent-child communication, child behavior, and family conflict. In-home support services attempt to decrease domestic violence, child abuse and neglect. Services are also directed toward reducing delinquency and improving social skills, school attendance, anger management, and adherence to curfew laws. The goals of family therapy are to improve family functioning and to reduce antisocial behavior (English, 2000).

Family and community support is a growing force in substance abuse prevention. Particularly important is what has come to be called the "Parents' Movement." Various groups provide a means of support for concerned parents, a mechanism for becoming educated about the problem of substance abuse, a vehicle for increasing community awareness about substance abuse, a catalyst for promoting change for their communities in a direction consistent with non-substance use, and a resource for schools. Some of these are:

Mothers Against Drunk Driving (MADD): This organization was founded by mothers whose children were victims of drunk drivers. Its 300 chapters nationwide emphasize activities to increase public awareness of the problem of drunk driving and promote public policy and legislation designed to curb drunk driving.

Students Against Driving Drunk (SADD): There are currently 18,000 local chapters in junior and senior high schools, as well as about 400 chapters in colleges. Like MADD, SADD focuses on the problem of drinking and driving in an effort to reduce alcohol-related auto fatalities. It does this through school-based and community-based educational programs about the dangers of drunk driving, media campaigns, and weekend hot-line services to provide safe rides for teenagers who have been drinking.

National Federation of Parents: The National Federation of Parents for Drug Free Youth (NFP) was formed in 1980 to assist in the formation and support of local parent and youth groups across the country with the expressed purpose of eliminating drug and alcohol use among youth. NFP advocates greater parental involvement in determining the values and environment of their children. It sponsors annual national conferences, distributes public service announcements, and lobbies state legislatures and Congress. It currently has 800 affiliate parent groups.

While there is virtually no objective evaluation data available, national anti-drug organizations such as MADD have undoubtedly had an impact on awareness of substance abuse and its adverse consequences. Likewise, no objective data exist to support the efficacy of these groups with respect to substance abuse prevention.

An excellent example of a comprehensive community-based substance abuse prevention approach is Project STAR (Students Taught Awareness and Resistance), comprised of 15 contiguous communities making up the greater Kansas City metropolitan area. The core of this community-based substance abuse prevention program is a school-based curriculum designed to teach resistance skills to middle and junior high school students. The prevention- intervention modalities are designed to increase individual self-efficacy, build personal skills, and apply resistance skills to specific interpersonal situations involving drug offers or drug availability. The outcome of 10 social resistance skills training sessions, a parent component consisting of homework assignments from the school-based intervention, and a mass media intervention involving coverage from newspaper articles and television clips concerning issues related to non-substance use, resulted in persuasive evidence that this comprehensive prevention approach is effective.

The above represent examples of formal structures for family and community support for the school's prevention program. Many other possibilities exist that can be implemented to support a school's unique needs (English, 2000).

Assessment of the impact of the four components of a comprehensive prevention program—curriculum, teaching, school climate, and family and community support—individually and collectively, should be ongoing to evaluate the effectiveness of prevention efforts. Unfortunately, assessment and evaluation approaches in prevention to date have been extremely limited. Assessment could be used more effectively, particularly in identifying the school problems of use and abuse of substances and individuals who are at-risk for substance abuse.

Summary

As was emphasized in Chapter Two, school is a powerful influence in American society. Thus, it is logical that schools would be called upon to develop comprehensive prevention efforts to develop youth who have the personal strength and necessary skills to make healthy choices. This chapter identified the roles of the primary partners — the school administrator, the school counselor, and the teacher — in relation to the implementation and delivery of the prevention program. The chapter then outlined the components of an effective school prevention program. The components include a school prevention curriculum (K-12), teacher competency and skills, school climate including extra-curricular prevention activities, policies and procedures, and family and community support. A specific "prescription" or steps for implementing the effective school prevention program discussed in this chapter will be provided in Chapter Seven, "Prescription for Change."

Chapter Five

The School Counselor's Role

School counselors serve as advocates and agents of change for students to insure their optimal cognitive and personal development. While they inform their clients of opportunities to participate in social and community affairs, they also need to look for opportunities for involvement themselves. They must be advocates of individual development and growth plus agents of social activism if they are to remain faithful to their profession and their advocacy role. As social activists, school counselors, as well as other school personnel, can promote awareness of the damaging effects of poverty, poor housing, overcrowding, undernourishment, and discrimination. School counselors, in their individual and group efforts, can enhance awareness of the influence of the environment, encourage recognition that change is possible, and facilitate the development of institutional and individual resources and skills for creating change.

School counselors can and should impact a broader environment than the school. Pursuing activities to facilitate needed change locally, statewide and nationally as well as in schools is viewed as a professional responsibility of the school counselor. The social and economic risk factors in the larger society can be directly modified by mental health policy and practice at every level of government. School counselors can make their views known to local and national leaders through votes and letters, publications, and seminars. They need to be involved in the process of seeking change in mental health policy and practice at the level of those who have the power to fund, legislate, and affect the structure of the environments in which counselors work with youth. School counselors are often faced with the fact that many of the needed solutions require fundamental sociopolitical changes. As examples, poverty, inadequate nutrition and housing, discrimination, and lack of information on birth control cannot be prevented with crisis-oriented programs or, in most cases, with comprehensive school prevention programs. Impact in these areas means change, preventive in nature, in the family and community environment that fosters such problems. Thus, in these areas, individual counselors must pursue introspection, critical analysis, and, hopefully, action. The modeling of social activism by school counselors can serve as a powerful tool to help young people recognize their own potential to change or improve the course of their lives.

For further information on the counselor's role as advocate and social activist, the reader is referred to Lewis & Bradley (2000) and Lee & Walz (1998). In addition to this perspective, this chapter addresses a brief history of the school counselor's role, the importance and process of facilitating change, the rationale and procedures for and barriers to prevention program development, and the related school counselor role.

Change Agent

As outlined above and throughout the chapters, this text endorses a leadership role for the school counselor in bringing about the planned change in the school to implement an effective and comprehensive school prevention program. Change is inevitable and of two kinds - that over which we have control and that to which we react. Schools and their personnel have tended to react rather than lead the change process. This is a pattern needing change.

The idea that the school counselor should serve as an agent for change within the school is not new (Baker & Shaw, 1987). However, school counselor practice for the most part has not accepted this idea. Even though current guidance concepts and practices related to comprehensive guidance and counseling programs are becoming the norm, school counselor practice is predominantly still focused on changing the student to fit the institution rather than changing the institution to better support both the cognitive and personal growth of students. Past proposals suggesting the school counselor should be a change agent, particularly in relation to implementing prevention programming in schools, may not have prescribed the specific steps needed. This text identifies the steps needed in Chapter Seven, "Prescription for Change."

Tremendous changes have occurred in school counseling and guidance over the past hundred years. The use of various kinds of tests, prominent in early guidance practices, has diminished significantly except in the area of special education. Group counseling, seldom visible in the 50s, is now in common use. Career development, first known as vocational guidance, has assumed an increasingly broader role.

In addition to changes in techniques, more fundamental changes have occurred in school guidance and counseling. Fifty years ago, guidance specialists could comfortably argue that guidance outcomes were intangible. Today, guidance specialists are responsible for establishing clear goals and objectives and assessing the outcomes of guidance services. From its first beginnings, guidance has espoused the importance of providing service to all children. However, in practice, it has concerned itself with students whom teachers, administrators, and parents have believed were in need of special help. One example would relate to students who are referrals related to Public Law (PL) 94-192, the Education for All Handicapped Children Act. Another example would be students perceived as having a substance abuse problem and referred for counseling.

By the beginning of the 20th century, the United States was involved in the Industrial Revolution, a period of rapid industrial growth, social protest, social reform, and utopian idealism. Social protest and reform was being carried out under the banner of the Progressive Movement, which sought to change negative social conditions related to the Industrial Revolution. Guidance was born during the height of this movement as but one example of progressive reform. Its beginnings can be traced to the early vocational guidance concepts of individuals such as Frank Parsons. In the 1910s and '20s, guidance and counseling services were implemented in public schools as vocational guidance, with teachers appointed as vocational counselors. These "counselors" were provided with a list of administrative support duties but had no relief from their teaching duties and no additional pay (Gysbers & Henderson, 2001).

In the 1920s and '30s, concerns were being voiced regarding the need for identifying an agreed upon structure within schools to organize and direct the work of teacher/vocational counselors. Without such, having counselors perform "other duties as assigned" often became a problem. Teacher/vocational counselors were viewed as "handymen," performing the duties of visiting or substitute teachers, directors of lunch room, chairs of various committees, or assistant principals. One solution highlighted in the 1930s through the '50s was the adoption of the framework of "pupil personnel work," concerned primarily with bringing students into the educational environment under circumstances which enabled them to obtain maximum development. During this time, the vocational emphasis began to be overshadowed by a more clinical perspective and emphasis on counseling and testing (Gysbers & Henderson, 2001).

In the decade of the '60s, partly as a result of the National Defense Education Act of 1958, teacher/counselors of previous years were replaced by full-time counselors. Pupil personnel work, now called pupil personnel services, continued to be the preferred organizational system. School counselors, school psychologists, nurses, and social workers provided the various services. The predominant services for the school counselor were orientation, assessment, information, counseling, placement, and follow-up. During this time, these services were viewed as ancillary and placed counselors mainly in remedial roles, not seen by most within the school as in the mainstream in education.

Historically, as outlined in Gysbers and Henderson (2001), the counselor in the school setting has been linked to the guidance program as the guidance counselor. From the 1950s through the 1980s, many educators and practitioners have tried to replace that term with school counselor in an attempt, with varying success, to de-emphasize the guidance activities of the school counselor. Guidance activities are now more in vogue under the evolving conceptual interest in comprehensive guidance and counseling programs.

Beginning in the 1970s and continuing to date, the concept of guidance and counseling for personal and career development began to emerge. It emphasized a reorienting of guidance and counseling from an ancillary involvement into a more integrated role. This concept, defined in practice as the comprehensive guidance and counseling program, is becoming the preferred way to organize and manage guidance and counseling in schools. Its perspective on human development and related competencies such as student knowledge, skills, and attitudes mastery is referred to as life career development. "Life career development is defined as self-development over a person's life span through the integration of roles, settings, and events in one's life" (Gysbers & Henderson, 2001, p. 49). Thus, the total person involved in many roles, settings, and events is the emphasis of life career development. This emphasis presents an organizing and integrating concept for understanding and facilitating human development and for developing a comprehensive guidance and counseling program. Professional support for this new guidance emphasis is found in the American School Counselor Association's release of *The ASCA National Model: A Framework for School Counseling Programs* (ASCA, 2003). This model identifies a comprehensive approach to counseling programs and identifies strategies for school counselors and school counselor teams to design, coordinate, implement, manage, and evaluate their programs for students' success. This model identifies the school counselor's role in implementation, leadership, advocacy, and system change to switch emphasis from service-centered for some of the students to program-centered for every student. This model fits well with the proposed counselor responsibilities related to prevention outlined in this text.

Comprehensive Guidance and Counseling Programs

A Comprehensive Guidance and Counseling Program consists of three elements: content, organization, and resources (Gysbers & Henderson, 2001). The content element identifies the competencies considered important by school districts for students to master. The organizational framework includes structural components to include definition, rationale, and assumptions. Four structure program components are identified. These include: 1) guidance curriculum, which includes structured group activities and classroom presentations taught by school counselors; 2) individual planning, which includes advisement, assessment, placement, and follow up; 3) responsive services related to student need such as individual or group counseling, consultation, and referral; and 4) support to the school such as management activities, consultation, community outreach, and public relations. The resource element relates primarily to counselor time. A suggested distribution of school counselor time by grade across these four functions in provided for in Table 1 (Gysbers & Henderson, 2001).

The school counselor commitment to a Comprehensive Guidance and Counseling Program reflects an important commitment to the development of student personal competencies that are also identified as important to prevention. Under this program, these competencies are "taught" by school counselors in the classroom as part of a guidance curriculum, which typically consists of competencies and structured activities presented systematically from kindergarten through twelfth grade. Note per Table 1, it is suggested that 35 - 45% of the counselor's time be committed to teaching the guidance curriculum in the elementary school, 25 - 35% in the middle-junior high school, and 15 - 25% in the high school. While the guidance curriculum competencies and structured activities are prevention-related and represent a good first step, these guidance services are not enough. As noted in Chapter 3, the school counselor must play a broader role in the school by assisting teachers in their delivery of a K-12 prevention curriculum, helping teachers develop more facilitative interaction skills, ensuring an anti-drug environment within the school, and obtaining family and community support for school efforts. These activities could be addressed under the "System Support" time for counselors within the Comprehensive Guidance and Counseling Program.

Table 1
Suggested Distribution of Total Counselor Time (Percentages)

	Elementary School	Middle/Junior High School	High School
Guidance Curriculum	35-45	25-35	15-25
Individual Planning	5-10	15-25	25-35
Responsive Services	30-40	30-40	15-20
System Support	10-15	10-15	15-20
	100	100	100

The underlying concern for the provision of guidance services to all students (Gysbers & Henderson, 2001) may be a reaction by counselors to a perceived over-emphasis on providing special education or remedial counseling services. It may be simply a return to the original philosophical assumption that guidance services are for all students which brings with it different strategies, techniques, challenges, and opportunities. Whatever the cause, one way to address the concern is to institutionalize the guidance commitment to all students through an increased emphasis on developing programming to prevent problems as opposed to remediating them. This strategy involves more indirect guidance service, such as consulting, advising, and training in curricular and extra-curricular areas, than traditionally provided in a direct manner (counseling and assessing on an individual basis). It also changes the role of the school counselor to that of an expert, change agent, and active leader in working collaboratively with others to insure the school's environment is conducive to personal as well as cognitive growth.

Prevention Benefits to Guidance

The most fundamental benefit of prevention programming to the guidance program is that primary-prevention approaches are intended to reach *all* students. Thus, prevention programming can assist guidance in returning to its roots of being a service intended for all students. It is only in recent years that the guidance focus has changed from addressing all to working with only a fraction of the students in school. One benefit of providing guidance services designed to reach all students is that the school counselor comes more into line with the basic school philosophy that all children should be served. Implementing prevention programming provides a strategy for a guidance program to provide a wide range of effective curricular and extracurricular services, including services to all students as well as those in specific need, the typical as well as the atypical student. A guidance program addressing personal and cognitive development moves guidance from the periphery of education into the center.

Another benefit of prevention programming within guidance is that the return will be great for each guidance dollar invested. In prevention efforts, the typical unit is the group rather than the individual. When services are provided to teachers, parents, or students as groups, these services are capable of being generalized beyond the present class of students, and, in the case of parents, beyond a single child. Successful primary-prevention programs should diminish to a large degree the need for high-cost individual remedial programs delivered to specific children with specific problems. Motivation of teachers with respect to participating in a remedial process may be low while the motivation of teachers and parents for participating in prevention-oriented functions is likely to be considerably higher.

An additional benefit for guidance is heightened visibility of guidance specialists. Guidance specialists are often relatively invisible in terms of what they do. Counselors often stick to their offices, psychologists to their testing rooms, and school social workers to functions outside the school itself. Preventive services, proposed as the responsibility of the school counselor, are, almost by definition, services provided in highly public and visible settings. Assuming that such services are viewed as effective, heightened visibility will improve the image of the school counselor.

Implementing prevention efforts through and within guidance services in schools helps guarantee that all students have the potential to benefit from various professional counseling and guidance services to which they are entitled. These services are much broader than those provided historically, i.e., facilitating college choice or working with problem or special education students. Implementing prevention components with the guidance program and the school has the potential to provide practical and effective ways to meet the needs of all students. It also moves the guidance program to a more central position related to the educational mission of the school.

Conditions for Change

A first condition for change is awareness by school counselors of the need and the broad conditions necessary for effective prevention programming in schools. From this follows a commitment on the part of both guidance staff and administrators to the delivery of effective guidance and prevention services to all children. Next must be a willingness by the school counselor to forego some traditional activities. A willingness by all school personnel to invest time in planning must then be demonstrated. Regular school personnel, not adjuncts, must develop the necessary skills to provide curricular and extra-curricular primary-preventive services. Unless counseling and guidance and prevention services personnel are members of the permanent staff, both the personnel and the services they provide are likely to be viewed by others in the school as ancillary to the basic purposes of the schools.

In the process of deciding whether to implement prevention activities as part of the guidance program, the school counselor must reflect upon two questions. First, what are the appropriate goals of the school? To date, two goals are generally agreed upon. One is that schools must foster cognitive development. The other is that schools must provide a situation or learning environment where cognitive development can take place optimally. The second question is, what are the proper contributions of a school counselor, school psychologist, or school social worker to students in the school setting? If the guidance specialists agree that helping to optimize children's learning and their personal/social development are appropriate goals, then the obvious need exists to link prevention activities with the guidance efforts in schooling.

A broader question is specific to whom guidance services are provided. While there appears in the field to be an articulated commitment to services for all students, in practice the bulk of services provided by the school counselor continues to be provided to a small segment of the student population. If the school counselor's decision is to truly implement services to all students, then it becomes clear that implementing primary, secondary, and tertiary prevention services within the guidance program and the school is required.

A systematic way for school counselors to become change agents in relation to prevention involves the development and implementation of four position statements. These are: (a) a rationale, (b) a set of goals and objectives, (c) a description of functions leading to accomplishment of the goals and objectives, and (d) a description of the evaluation strategies for each goal and objective (Baker & Shaw, 1997). The position statements are addressed in Chapter Seven, "Prescription for Change," in relation to specific steps needed to implement a comprehensive prevention program. Once a rationale statement is agreed upon, program goals and objectives with the general and specific outcomes desired must be defined. These should target indirect guidance services, such as school counselor leadership in implementing prevention curriculum and programs and consultation with parents, teachers, students, and community, as well as direct services; such as individual and group student contacts related to the secondary and tertiary levels of prevention. Specific services are then identified as appropriate in meeting goals and objectives in the primary, secondary, and tertiary levels of prevention. Evaluation then follows to determine whether or not goals and objectives have been met. Unfortunately, as will be discussed in the Chapter Six section "Evaluation," most evaluations do not do this but instead simply identify and quantify the amount and types of services provided.

Prevention Within the Guidance Program

The three levels of prevention can be easily implemented within a guidance program. Primary prevention efforts in relation to curriculum are designed to empower students and avoid problems. These can be considered indirect guidance services in that school counselor services are provided to teachers, administrators, parents, or others responsible for students. Primary prevention efforts help teachers and parents work more effectively with students. Their focus is on all students through improvement of the learning environment. Such efforts have evolved within schools from early work as far back as the 1940s with Bullis' emphasis on human relations skill development. Aspy and others then identified the need for teacher communication skills for effective student learning and, more recently, identified the importance of skill development in personal and social growth within the curriculum (Moore, et al, 1991). In implementing a comprehensive guidance and counseling program, school counselors can be delivering the primary prevention curriculum. This fits well with suggestions that cognitive goals should be the major focus of the school counselor. The idea that school counselors should be concerned about learning outcomes can be traced to Wrenn who suggested guidance goals should be broadened to include cognitive outcomes (Gysbers & Henderson, 2001). School counselors' involvements in primary prevention efforts should include both cognitive and affective emphasis with competence identified as a primary goal.

Secondary prevention efforts provide services to remediate early-identified problems. School counselor responsibility is the same for tertiary prevention efforts which are predominantly provided by the counselor based on referrals from teachers, school psychologists, or school social workers. Tertiary services are also obtained in the community on a referral basis by the school counselor. Tertiary prevention efforts including provision of therapeutic interventions necessary with a small percentage of the student population. Implementing secondary prevention efforts, such as teen court where peers serve as judge and jury to review substance abuse offenses, are also proposed as the responsibility of the school counselor, although the school psychologist and school social worker are occasionally involved in providing these. While school counselors play important and varied roles in prevention at the primary, secondary, or tertiary levels, the primary role, as advocated in this text, is for the counselor to serve in a leadership role within the school in implementing prevention programming. After facilitating the implementation of a comprehensive prevention program, the school counselor serves as an advocate and consultant in enhancing the primary prevention efforts within the curriculum. This role may include working with teachers in designing classroom strategies that support the development of resiliency in their students.

Academic achievement is a significant protective factor in prevention of substance abuse. In addition to services supportive of curriculum efforts, the school counselor collaborates with other school professionals to provide or insure availability of support services, such as parent skill training, peer counseling, support groups, and teen courts. School counselors are also in an excellent position and need to work with parents on strategies to support children in achieving success in the classroom. In all aspects of prevention programming, school counselors are challenged to get out of their offices and into the school community where their skills in interpersonal communication, problem solving, dispute resolution, and listening can be utilized to promote climates of support and nurturance that mitigate risk and reinforce individual and community resiliency.

Barriers to Implementing Prevention

Given the benefits of implementing prevention, there still exists several major barriers for school counselors. The first of these relates to the need to gain a clear knowledge of what prevention is and how it applies to schools. A second barrier is the apparent preoccupation of school counselors and other guidance specialists with addressing remedial populations and problems through devotion to one-on-one counseling. The preoccupation on individual counseling has helped remove guidance counselors from the mainstream of education. A third major barrier is the continuing assignment of certain tasks to school counselors, school psychologists, and school social workers. For example, studies show school counselors spend about half of their time scheduling students into classes. School psychologists' primary activities are related to testing and assessment, particularly given requirements under PL 94-192. The school social worker's major focus is the home visit. Until guidance specialists, and the school counselor specifically, are allowed and willing to give up some of the traditional school roles and tasks they have assumed, they will not be able to implement primary prevention effectively within schools.

Despite many years of emphasis on the importance of mental health and personal emotional growth for students, neither the public at large nor schools appear to be fully ready to accept these goals as primary responsibilities of the schools. When endorsed in individual schools, the personal growth programs usually have been grant-funded and not permanent. The responsibility for demonstrating how affective growth and cognitive growth are related falls directly on guidance specialists. School counselors, in particular, need to emphasize that cognitive development improves as mental health improves and that, when conditions promoting affective development of students are maximal, teaching becomes easier and more impactful (Witmer & Myrick, 1980).

Counseling Skills - Perspective on Tertiary Prevention

To be effective with any client, all counselors first must have the ability to develop an open, collaborative relationship wherein the client perceives trust and commitment (Sales, 2000). Carl Rogers identifies, and research supports, this ability as related to the counselor's skills in conveying, in interaction with clients, unconditional positive regard and empathic understanding (Sales, 2000c; Sexton, Whiston, Bleuer, & Walz, 1997). Witmer & Myrick (1980) document these same skills are needed by teachers to insure greater cognitive growth among students. In addition to these skills, the counselor must provide focus for the process by addressing the client's presenting problems directly and identifying client need for change (Austin, 1999). Counselors of clients with substance abuse problems often find this process difficult because of the chronic nature of interrelated destructive attitudes and co-existing disorders these clients bring to counseling. Once the problem and the client's need for change are identified, the counselor must be able to articulate and implement counseling intervention strategies perceived by both the counselor and the client as appropriate to the client's need to change.

These process considerations in counseling clients with substance abuse problems hold to be true for counselors working not only in schools, but also in rehabilitation, mental health, and social work settings. The counselor's emphasis is on the person not the substance abuse problem (Sales, 2000c). Additional knowledge and skill on the part of the counselor relates to being able to assess the extent and impact of a student's substance abuse problem and the student's need to change. Familiarity with and ability to utilize standardized assessment instruments specific to substance abuse will help the counselor in this assessment process. Familial and social environment assessment also is required to identify the extent of the student's support systems and to what degree he/she utilizes them. The school counselor's ability to identify the needs of the student and the quality of counseling and related treatment intervention strategies obviously are linked to his/her assessment and diagnostic skills (Sales, 2000a).

School counselors should be thoroughly familiar with the facilities and services in their community to insure proper referral for students with substance abuse problems. Referral options are determined by student need and are collaboratively agreed upon as appropriate by the counselor and the student and his/her family. These include short-term, inpatient care lasting three to seven days for withdrawal from substance abuse, or intensive, outpatient programs lasting eight to twelve weeks wherein students maintain educational and family responsibilities while participating in treatment. Another option, the half-way house, provides moderately structured and supportive residential treatment lasting for three to six months, wherein successful living within the environment becomes part of the treatment plan. Other options include therapeutic communities; structured, highly intensive, residential treatment programs such as Synanon, where clients may remain up to two years; and out-patient treatment programs of two kinds - drug-free clinics with services lasting four to six months and methadone or opiate clinics that a client may attend by medical referral for two to five years. Within these settings, group treatment is the predominant mode of therapy with individual counseling viewed as an adjunct (Sales, 2000b).

Putting it all Together

The following is a common sense approach as outlined in Baker & Shaw (1987, pp. 251-256) to the school counselor's moving into a change agent role by implementing and facilitating an effective substance abuse prevention program on a step-by-step basis within the school. This approach is expanded upon in Chapter Seven, "Prescription for Change." The first step is to decide that prevention is a legitimate emphasis of the school counselor and the guidance program with resulting commitment to bringing about changes. A second step is to create a perceived need and consensus for change within the school for implementing a prevention program. This is done through informal discussions with teachers and administrators wherever in the school the opportunity presents itself. It is also done through obtaining and sharing data indicating the factual and quantifiable substance abuse problems. Through this process, a critical mass (more than half) of school personnel will need to develop a perceived need for prevention services. Of critical importance is obtaining the school principal's support. The next step is to put together a school impact team, a group of individuals (teachers, other guidance specialists, parents, and staff) of no more than seven people, who are willing to serve as a planning and management group. The best scenario would be the sanctioning of this group by the principal who also would endorse the group's findings and plans for change. This team would then be provided the time and training to enable them to develop prevention goals and objectives across all components of school activity. This team first would pursue further assessments, if needed, to more specifically identify the substance abuse problem in the school (see Chapter Six section on Assessment). They then would develop relevant goals and objectives, implement curricular and extracurricular responses to the problem, and implement an evaluation plan, all of which would be formally developed in a narrative publication identifying the goals, objectives, and strategies for prevention. The team would continue as a monitoring and evaluation group to oversee progress, complete annual evaluations and reports, and generally serve as a resource of support and advice for personnel in the school. While these steps seem simple, they, in fact, are complex, and attainment of them requires a major time commitment on the part of everyone involved.

Chapter Six

Special Topics

A variety of special topics are briefly addressed in this chapter. These are important in relation to the school counselor's responsibility for implementing prevention programming. They include funding, needs assessment, evaluation, at-risk students, resiliency, cultural sensitivity, ethical dilemmas, HIV/AIDs, disabilities/special education populations, policy issues, legalization of drugs and future perspectives.

Funding

The primary resource need in implementing an effective school prevention program is manpower. Most prevention development and implementation efforts cost little except time and commitment. Prevention curriculum needs can usually be met through school budgets. However, if additional funds are needed for curricular or extra-curricular efforts, they will need to be pursued through outside resources.

Competition for funding in support of prevention efforts can be fierce, but funding can be obtained. Federal grants and some private foundations provide funds but they are difficult to tap unless you have experience and expertise in preparing competitive grant proposals. Requiring less grant expertise are state and local grant sources, both of which offer funds. Pursue these through inquiring with your state Department of Education Drug Abuse Prevention Office. The national office of the Substance Abuse and Mental Health Services Administration has a listing of all state directories. Other possibilities include local business and civic clubs which are often willing to support specific school prevention efforts. One can always pursue fund raising activities such as car washes, candy or flower sales, dinners, dances, raffles, refreshments at school athletic events, or individual donations. Often you can obtain from local businesses a commitment to match funds that are raised.

Needs Assessment

Success in prevention programming demands that the specific substance abuse problems related to the school are defined clearly and accurately and that appropriate strategies are developed to resolve them. Prevention needs assessment within schools involves identifying the extent and types of existing and potential substance abuse problems, current services available, and the extent of unmet needs to be able to plan prevention programming. While reviews of substance abuse assessment relate to evaluating individual substance abuse problems, the concern should be with the broader group prevention need. Needs assessment utilizes four types of problem data sources: drug use indicators, problem-behavior indicators, psychological or developmental characteristics, and social or economic conditions.

Drug use indicators relate to the incidence, the rate of which individuals are developing new substance abuse problems, and prevalence, the number of individuals who have substance abuse problems. Such indicators include survey data figures on drug arrests and number of persons in treatment. Problem-behavior indictors are considered secondary indicators in that they are believed to be correlated with drug abuse; these include crime rates, vandalism, truancy, and drop-out rates. Psychological or developmental characteristics are assessed since they are suspected of being correlated with future drug use. These include aspects of family interaction, development of self-esteem and values, and individual interaction skills. The fourth indicator is social or economic environmental conditions that correlate highly with drug abuse. Some of these are poor housing conditions, persistent unemployment, and discrimination. The most common method of obtaining these data is related to simply asking questions. This is done through verbal interview, questionnaire, telephone or personal surveys of all or a sample or target population within schools, and/or interviews with community leaders and key informants. Needs assessment helps identify the problem, an understanding of which can lead to objectives for prevention programming.

Many methods are available for assessing need for prevention, such as assessing/analyzing the numbers of students having substance abuse problems. In assessing need, survey questionnaires on prevalence are available through State Departments of Education and from NIDA. Appendix H identifies nine instruments used in assessment which are available in a book developed by the National Institute on Alcohol Abuse and Alcoholism. These instruments can be used directly or as models for developing assessment instruments to meet the unique needs of a particular school.

Evaluation

Evaluation has proven to be a weak link in prevention efforts. Past attempts at evaluation of prevention programs indicate that, while improvement in knowledge and some attitude changes may occur, there is little evidence demonstrating that improvement in these areas alone results in a reduction or elimination of substance abuse. This lack of evidence of program effectiveness is believed to be attributed to multiple causes of substance abuse and the difficulty in evaluating only one or two components of a comprehensive prevention program. Most prevention models in recent years have addressed a combination of host and environmental factors. The prevention programs that have resulted in the best results are those that are comprehensive, with research-based strategies that address clearly defined multiple curricular and extra-curricular components (Jansen, Glynn, & Howard, 1996).

Several recent evaluation studies support the development and implementation of comprehensive prevention programs. Research supports the impact of curriculum, such as The Life Skills Training Program (Botvin & Botvin, 1997), a classroom-based program design to address multiple risk and protective factors. The Program consists of a three-year prevention curriculum targeting middle school students. It covers drug information and resistance skills, self-management skills, and general social skills. Research results demonstrate that this prevention intervention can produce decreases in the use of tobacco, alcohol, and marijuana and additional "booster" sessions can help to sustain program effects.

The favored paradigm for evaluating primary prevention incorporates multiple intervention strategies delivered through a variety of settings tailored toward the target population. For example, Pentz, Bonnie, & Shoplund (1996) have been successful in reaching the entire community with a comprehensive school program, media efforts, a parents' program, health policy change, and community organization. Research results of this project show positive long-term efforts. Students who began the program in middle school showed significantly less use of marijuana, cigarettes, and alcohol than those who were not involved in the comprehensive program.

Past efforts at evaluating prevention programs provide guidance for effective evaluation. Several factors influencing evaluation must be considered. One is that the broad goals of prevention are very imprecise, thus very specific target behaviors related to these must be identified for evaluation and measurement. A second consideration is the inability to isolate a prevention experiment from outside influences. In most instances, this outside influence must simply be recognized in discussion of outcomes.

True scientific evaluation of prevention efforts within schools is impossible to attain. However, assessing outcomes of prevention objectives can be done through on going evaluation. This process includes developing goals which are broad statements regarding outcomes sought; defining related prevention objectives which are more specific, limited, and measurable analyses of results compared to objectives; and developing appropriate recommendations for changes in the goals and objective. Ideally, attainment of program objectives will imply that general goals have been reached.

Effective prevention efforts have clear, concise goals and measurable objectives. Two strategies for evaluation are as follows:

Process Evaluation. These are strategies that indicate certain activities have been completed and answer questions such as the following: Did the planned service do what it proposed to? Was it successful in completing strategies? Are programs actually operating in accordance with plans and expectations?

Outcome Evaluation. These strategies can be short-term or long-term. Short-term outcome evaluation involves determining if parents, students, teachers, and other participants learned anything or changed attitudes or perceptions as a result of the prevention program. Long-term outcome evaluation measures behavioral changes in the school such as changes in alcohol or drug use, dropout rates, or referrals for disruptive problems. Outcome evaluation attempts to verify the impact of services by measuring the degree of impact on individuals based on the intervention. A useful evaluation contains both process and outcome measures.

Studied efforts at planning and evaluation are as important as the quality of changes implemented to meet the problem. Assessing outcomes against prevention objectives for new prevention strategies is needed to insure the program's effectiveness and enhance its development. In spite of the difficulty in evaluating it, prevention does work. It is a vital key to solving the drug problem and should be vigorously pursued.

At-Risk Students

The term "at-risk" has appeared frequently in the social science literature over the last decade and a half and is used differently in different disciplines. Examples of being at-risk are highlighted in Chapter One. In education, at-risk refers to students who are at-risk for dropping out of school or who may not be developing enough knowledge and skill to succeed in the future school years or upon graduation. A risk denotes a set of presumed cause-and-effect dynamics that place an individual in danger of negative future events. Young people who use alcohol are at-risk for illicit drug use. Those who use illicit drugs are at-risk for drug abuse. Conduct disorders, aggression, and low achievement in early grades predict later delinquent and antisocial behavior. Thus, a specific behavior, attitude, or deficiency provides an indication of later problem behavior. At-risk designates a situation that can be anticipated if no intervention occurs (McWhirter, et al, 1998).

At-risk youth do not acquire the knowledge, behavior, attitudes, and skills they need to become successful adults and frequently exhibit dysfunctional patterns of behaviors, cognitions, and emotions in their early school years. If these patterns are not reversed, they are at-risk for multiple problems that include school failure, drug use, teen pregnancy, delinquency and suicide (McWhirter, et al, 1998).

Resiliency

Despite debilitating environmental, familial, and personal experiences, many young people do not develop, as would be expected, at-risk behaviors. They instead exhibit competence, autonomy, and effective strategies to cope with the very negative world experiences around them. They exhibit resiliency, a capacity to cope effectively with the internal stresses of vulnerability concurrently with the external stresses imposed by the environment (Haggerty, Sherrod, Garmezy, & Rutter, 1996). Researchers (Arnold, 1995; McWhirter, 1994; Randolph, 1995; Werner, 1995) have found that three related but distinct areas provide protective qualities resulting in the resilient child. These areas are: 1) external support systems at school, work, or church which can provide an individual with a sense of meaning; 2) an individual belief system; and 3) an internal locus of control. In all of these areas good adult support and involvement is important. The family milieu can provide emotional support during times of stress. The development of cognitive skills, styles of communication and interpersonal relating skills are linked to resiliency. A child who has a good relationship with one caregiver demonstrates greater resiliency (Burns, 1994; Bushweller, 1995a; Werner, 1995). Resilient youth feel self-confident, in control, they are pro-active problem-solvers, able to cope with distressing experiences constructively. They are able to communicate well with others and are able to gain positive attention and support from others. They maintain a positive outlook and are competent in social, school, and cognitive areas. Non-resilient or at-risk youth are the exact opposite (McWhirter, et al, 1998).

Thus, in order to support prevention and optimal individual growth, schooling must support developing resiliency skills. Critical school competencies in terms of basic academic skills and survival skills need to be imparted within the curricula and extra-curricular activities in schools. These are addressed in detail in Chapter Four, Comprehensive School Prevention Program.

Cultural Sensitivity

One criticism of school-based prevention programs is that they may not be effective with students who are at the highest risk for substance abuse. Prevention programs historically have been designed from a mainstream cultural perspective which has focus on white, in-school populations (Hawkins, Catalono & Miller, 1992). However, many current prevention initiatives have been developed within a context of respect for cultural differences. These initiatives have overcome the myths, stereotypes, and misconceptions about minorities and are grounded in a socio-cultural worldview specific to the individuals to be served (Reid & Kampfe, 2000). For an excellent summary of cultural values, socio-cultural perspectives, risk factors, barriers to treatment, and prevention with American Indians and Alaskan Natives, Asian-Americans, African-Americans and Hispanics, see Schliebner and Peregoy's (1998) chapter on *Working with Diverse Cultures: Treatment Issues and Characteristics* in Stevens-Smith & Smith.

Some culture-specific prevention and treatment programs warrant further exploration. Some suggest the need to include building on the role of the church with African-American and Hispanic individuals with substance abuse problems. With these groups, the church rather than Alcoholics Anonymous may be considered the place to share and address problems outside the home or school. Limited research exists among Asian-and Pacific-American populations. In comparison, the use of substances, particularly alcohol, among the American-Indian population has received great attention. Alcohol contributes to four of the leading causes of death for American-Indians and alcohol prevention and treatment programs have yielded poor results (Reid & Kampfe, 2000; U.S. Department of Justice, 2000). Continued study and respectful response is needed to insure prevention efforts are sensitive to cultural differences.

Ethical Dilemmas

The school counselor needs to be aware that a variety of ethical dilemmas exist relative to implementing the school's prevention program. While a school counseling code of ethics has been available through the American Counseling Association and similar codes have been developed specifically for counseling clients with substance abuse problems by the National Association of Alcoholism and Drug Abuse Counselors and the International Association for Addictions and Offenders Counselors, all potential ethical dilemmas are not covered by these codes. Of particular concern is the area of confidentiality concerning drug use, lapses in abstinence, or drug supplying. The school counselor and other school personnel often get caught in confidentiality dilemmas between the student, referring agencies, family, and law enforcement groups. When and under what conditions confidentiality can be breached needs to be clearly considered and clearly articulated to the students and their families. Another area of consideration relates to coercive referral versus voluntary involvement. Quite often in doing what is "best" for others, relating respectfully with others is violated.

As multiple interventions are implemented to address an individual's substance abuse, numerous problems surface in terms of sharing information. How much, with whom, how often, and under what conditions are but a few of the considerations that should be thought through early on. Decisions in this area may have to be determined on a case by case basis. If so, decisions should be based on what is best for the client, the policies of the school, and how the decision fits with the rule of no harm to self or others (Stevens-Smith, & Smith, 1998).

HIV/AIDS and Related Sexually Transmitted Diseases

Substance abuse can lead to irresponsible or risky sexual behavior, a serious consequence of which other than pregnancy is sexually transmitted diseases (STDs). STDs present extremely serious health consequences for sexually active young people. Rates of STDs are escalating and more than three million teens acquire an STD every year (Donovan, 1993). Chlamadea, an infection of the vagina or urinary tract, is the most commonly diagnosed. Other common STDs are gonorrhea, genital warts, herpes, and syphilis. The health consequences of STDs can be irreversible and AIDS and some herpes are incurable.

Irresponsible high-risk sexual behavior, such as unprotected sexual intercourse, as well as intravenous drug use, makes one vulnerable to contracting HIV, which leads to AIDS. In 1995, 13 to 19 year olds had a reported estimate of 2000 cases of AIDS. While this is a small percentage of the overall cases across all ages, the number of cases in teenagers doubles each year. Data would appear to indicate many in this age group have HIV which will become AIDS after an average of ten years (Center for Disease Control and Prevention,

1994) and are unaware they carry the virus until they infect others. In 1995, 17,000 20 to 24 year old young adults represented 80% of the individuals diagnosed with AIDS. Ethnic minority and gay youth are particularly vulnerable to AIDS. Hispanics (14%) and African-Americans (25%) are over-represented (Center for Disease Control and Prevention, 1994) with half of all teenagers known to have the disease being members of ethnic minority groups. Sexually active gay males are particularly vulnerable given their frequent involvement in unprotected sex with other males. Teenagers with attitudes of risk-taking and feelings of invulnerability and behaviors such as high sexual activity, multiple sex partners, and ineffective, sporadic or no condom use are very vulnerable to contracting HIV/AIDS (Donovan, 1993; McWhirter, et al, 1998). The rise of AIDS adds another source of societal concern about drug use, especially when it involves sharing of needles and sexual contact with intravenous drug users, who have high rates of AIDS. The urgency of providing curricular and extracurricular prevention efforts which can be effective in dealing with teenage drug use and sexuality issues cannot be overestimated (Greenfield, Finkbiner, & Bishop, 2000).

Disabilities/Special Education Populations

Individuals with disabilities and their risk for substance abuse provide a major challenge for school counselors. In a society too often preoccupied with defining a person in terms of his/her disability, schooling and prevention efforts should offer individuals with disabilities the opportunity to define himself/herself in terms of his/her abilities. School counselors should keep in mind that physical accessibility to and availability of prevention and interventions, including treatment, are the primary issues for the majority of individuals who have a disability and abuse substances.

Students with disabilities are at a higher risk of alcohol and other drug problems (Join Together, 2000; Sales, 2000c). Studies have suggested the substance abuse problem to be higher than that of the non-disabled and estimated to be as high as 80% among some subgroups within the population (Sales, 2000c). Risk factors contributing to higher substance abuse problems among students with disabilities include easy access to drugs; desire to avoid reality; frustration with school; peer alienation; chronic pain; feelings of greater differences than peers; few social supports; and enabling families, friends and professionals, who often condone drug abuse to avoid confrontation (Connecticut Clearinghouse, 1998; Sales, 2000c). For data specific to prevention needs of individuals with traumatic brain injury, deafness or hard-of-hearing problems, mental illness, mobility, blindness or visual impaired, attention deficit/hyperactivity disorder, mental retardation and learning disabilities, see Sales (2000c) chapter on "Substance Abuse and Disability." Barriers to prevention and treatment across all of these groups include:

1. denial of an individual substance abuse problem keep individual's with disabilities from participating in services;
2. physical and program accessibility issues; and
3. prevention and treatment staff who do not want to work with or do not know how to work with individuals with disabilities.

Counselors within the school need to insure that architectural, attitudinal, and communication barriers and discriminatory policies and procedures are not present. They should know the appropriate community resources and referral sources to utilize as needed in tertiary prevention, coordinate appropriate referrals, and provide follow up as needed (Sales, 2000).

Policy Issues

War on Drugs

The "war on drugs" that this country is supposedly fighting purports to attack the problems of the drug business. However, although politically correct, this "war" fails to attack the root causal factors that nurture many drug problems. These causal factors include poverty, racial prejudice and violence, lack of educational and job opportunities, the dissolution of communities, and personal, interpersonal, and family issues with which youngsters must cope. The war on drugs also fails to acknowledge or confront the inherent imbalance in the world's economic systems, which makes the drug trade both a viable and a profitable business (Falco, 1993). The war on drugs underscores the fact that we, as a society, deal with drugs and their resultant problems through the criminal justice system, and do not view addiction as a social and individual problem of prevention or treatment.

Prevention programs are an obvious and preferred form of intervention addressing the drug problem. Many young people have not yet experimented with substances and respond to primary prevention. The major benefits in prevention result from a focus on the pre-school and early grade levels.

Drug Free

The United States Department of Education has operated a Safe and Drug-Free Schools Program since 1994 under the Improving America's Schools Act. However, under this Act, *drug-free* does not include tobacco or alcohol. While *drug-free* may be politically popular, this concept may divert attention and resources from important efforts to prevent the use of tobacco and alcohol by young people.

An alternative conceptualization is the harm-reduction model. It is based on the premises that drug use cannot be eliminated from our society, that the misuse or abuse of any drug can cause harm, and that there are strategies that can be implemented to reduce the harm caused by misuse or abuse. One example is needle exchange (Mosher & Yanagisaka, 1991). Others include sobriety checkpoints and designated driver publicity campaigns, as well as "sting" operations to identify and penalize retailers who sell tobacco to minors.

Gateway Drugs

Many believe that federal prevention efforts have not focused on so-called "gateway drugs" as much as they should. Gateway drugs are those that precede the use of other drugs and are usually considered to be alcohol, tobacco, and marijuana (National Center on Addiction and Substance Abuse, 2000). One area that could be targeted is advertising. Currently, the tobacco industry is allowed to market a product that has no medically useful purpose, is highly addicting, and kills 400,000 people a year. Additionally, Madden & Grube (1994) found that the alcohol industry finances 1.5 alcohol commercials for each hour of televised sports. Grube & Wallack (1994) found that a significant association exists between awareness of beer advertising and the drinking intentions, beliefs, and knowledge of children.

Supply Versus Demand

Grinspoon & Bakular (1993) found "... little evidence to suggest that supply reduction programs in source countries have affected the supply or use of cocaine in the United States." In spite of this, federal spending continues to overwhelmingly emphasize supply reduction. In fiscal year 1997, 67% of federal dollars were spent on supply reduction and 33% was divided among prevention, treatment, and research. According to Grinspoon & Bakalar (1993), the war on drugs is actually a war on drug users:

> The federal budget for the control of illicit drugs has increased more than eightfold since 1981, and more than two-thirds of the total is devoted to the enforcement of increasingly harsh criminal laws. . . . Of the 1 million drug arrests each year, about 225,000 are for simple possession of marijuana, the fourth most common cause of arrest in the United States. . . Largely because we imprison so many drug users and petty drug dealers, the United States has a higher proportion of its population incarcerated than any other country in the world for which reliable statistics are available. (p. 357)

Legalization of Drugs

The idea of legalization of drugs is a controversial policy issue. Proponents of legalization argue that, if it were implemented, crime, violence, and diseases would be reduced. "Black-market" distribution would be reduced. The use of drugs could always be with clean needles and the quality of currently illegal substances could be controlled. The number of people incarcerated for possession or for crimes related to the need to buy drugs would be reduced drastically. More money would be available for reduced prison populations and the decreased need to interrupt drug supplies.

Opponents say use of currently illegal drugs would increase and use the current example of high abuse of alcohol by teens as an example of what could happen if other drugs were legalized. More addiction would occur and more social problems would result from increased access. Legalization is not as simple as either side would have you believe. First, drugs are legal. Alcohol and nicotine are drugs. The legalization issue usually involves discussions related to marijuana, cocaine, methamphetmine, and heroin. Second, proponents of legalization are actually supporting "decriminalization" by allowing individuals to possess small amounts of currently illegal drugs for personal consumption. Third, the concept of "legalization" can have numerous operational definitions with proponents from either side seldom communicating well with one another.

A first step in addressing this issue is to clarify terms. Discussions regarding legal aspects of substance abuse have to be kept separate from the concept of abuse. Most of us are drug users. We utilize a wide variety of prescription and over-the-counter medications to "treat" a variety of symptoms to make us function or feel better. Most of us are drug users as well when drinking coffee in the morning or afternoon, soft drinks in the afternoon, and alcoholic mixed drinks, wine, or beer in the evening. We use these drugs, much like abusers do, to stimulate us a little, to make us feel good or depress our anxieties and agitation. This is meaningful to restrict the terms drug abuse or substance abuse to those use patterns that impair an individual's ability to function optimally in his/her personal, social, and/or vocational life. It complicates rather than clarifies the legalization issue to label a 17 year old moderate alcohol drinker as a drug abuser when in fact he/she is only an illegal drug user. The use of an illegal drug should not automatically be considered drug abuse.

There are two separate and distinct issues here that should be kept separated for clear communication. One is that of legal-illegal drug use and one is use and abuse of drugs. The legal-illegal issue is a dichotomy and the use-abuse issue is a continuum.

With clear definitions, some basic agreements and conclusions can be reached. These are:

1. The physical and medical reasons against using some of the presently illegal drugs are valid only for some impure street varieties.
2. The regular intravenous use of heroin, the stimulants, and any drug is clearly dangerous and frequently leads to hospitalization and/or death.
3. The use orally of hallucinogens sometimes results in hospitalization.
4. The moderate use of pure drugs infrequently results in adverse effects.
5. The extensive use of drugs only occurs when the drug meets unfulfilled needs of the individual in a society.

6. Marijuana appears to be as safe (and as dangerous) in moderate social use as alcohol.
7. For every psychoactive drug in use, legal or illegal, there will be a certain percentage of users who are abusers.
8. The role of law enforcement in relation to the drug problem will continue to be ambiguous. Law enforcement works a social control only when the law is in agreement with the major themes and beliefs of the society.

A rational discussion and resolution of the role of drug use and abuse in our society needs to occur. Only then can the separate issue of legalization be addressed and resolved with law and law enforcement then clearly being reflective of our societal beliefs.

Future Perspectives

It is at best risky to try to predict any future perspectives on increased efforts at prevention. What can be said with certainty is that a possible increase in efforts depends on state and federal governmental policy and budget decisions and related support provided by major private foundations and corporations. Federal anti-drug laws are unlikely to move us closer to solving the drug problem so the need for prevention will have to become more obvious among the public. There will be increased public and political discussion and even experiments in legalization of the sale of illegal substances, particularly marijuana. As legalization begins steps toward reality, it will become even more essential that parents and teachers partner to insure effective prevention programs exist in schools. As this occurs, community and school prevention programs will increase in proportion to their success. The hope, more than a prediction, is that, in the future, community and school-based prevention programs will receive the support and financial backing they deserve.

Chapter Seven

Prescription for Change

In deciding to assume the role of change agent related to implementing prevention programming, two key decision points for the school counselor, as outlined in Chapter Five, need to be addressed. One is that prevention of drug abuse is accepted as a goal within schools and that the contributing factors to abuse must be the target of a successful school p nt relates to whether or not the counselor's role and service in the schools should broadly address the personal and cognitive development of all students. If the counselor decides this to be a legitimate role, then implementing comprehensive prevention programming provides an avenue to move guidance efforts into the mainstream of the schooling process.Such programming, in part, can be consistent with the recent guidance endorsement of life-career development as organized and integrated under a Comprehensive Guidance and Counseling Program. A more comprehensive and effective strategy, as outlined in this text, would be to insure teachers within the school integrate prevention and life-career development knowledge and skills into their curriculum and then deliver the curriculum effectively. Additionally, the school would need to 1) provide extra-curricular supports related to prevention, and 2) involve parents and the community in school efforts at prevention.

A first step in implementing an effective school prevention program can be just one individual's attempt at implementing a dream. This attempt can be by any school practitioner but it is proposed in this text that the school professional best positioned and able to implement effective preventive programs is the school counselor. Once the counselor sees prevention as a legitimate emphasis of the guidance program and commits to bring about change, the next step is to obtain support for change within the schools by developing a consensus for change. Such a consensus for change can be based on concern and perception. However, the most effective change efforts result from a factually identified and quantified problem, e.g., the incidence of substance abuse and the unique drug abuse problem within the school and what prior prevention intervention successes or failures have occurred. Through data collection and discussions with teachers and other school staff, more than half of the school personnel needs to develop a perceived need for prevention services. The higher in the administrative structure the recognition of need for change occurs, the more likely it is to be pursued. Thus, the endorsement of need for change by the principal in the individual school is a critical ingredient in the implementation of change. The principal's commitment to support resource allocations (staff time primarily) in this venture is critically important. Change related to prevention options and strategies needs to be developed by the primary stakeholders, the teachers, who should be involved in all stages of determining the change strategy. The informal and formal power structure of the school also must be committed to change.

When commitment to change is attained, the next steps include identifying a group of up to seven individuals (teachers, administrators, other guidance staff, community leaders, and parents) and providing them with the support and training needed to identify the school's unique response to implementing the prevention components discussed in this text. Research indicates this response must include the following components in order for there to be a preventative effect on students.

1. a prevention curriculum (kindergarten through 12th grade) which integrates skill development in competence, decision making, and communication skills;
2. the teacher's ability to empower students and to teach the prevention curriculum;
3. a school climate that is anti-drugs and has clear policies and procedures; and
4. family and community support of the school's comprehensive prevention program.

The specific activities in each of these areas are not as important as insuring activities in all of them. Pre-school compensatory programs, such as Head Start, should be part of the effort.

As is identified in the following, implementation of effective prevention programs in schools needs to include the above components: creation of a school/community advisory committee; implementing an educational curricular program; provision for teacher and staff in-service; development of drug-use policies and procedures; establishment of an identification and referral process; support for a variety of student extra-curricular prevention activities; monitoring of school climate to promote a healthy, cooperative atmosphere; developing ongoing parental and community involvement; and arranging for continuous assessment and evaluation procedures.

The development and implementation of a comprehensive prevention program should follow specific prescribed steps. However, the outcome will result in a unique program which will address the specific prevention needs identified for the school. As discussed in Chapter Five, the implementation of the prescribed steps is coordinated by the school counselor and implemented by a school prevention team. The prescribed steps are as follows:

1. Define the Problem. Using assessment approaches as discussed in Chapter Six, the completion of an accurate evaluation of the problem is a critical first step. This process is basically a problem of fact-finding. Through the use of surveys, questionnaires, or interviews, one must identify drug use, which drugs, by whom, where, when, why, extent of problem, who is distributing drugs, where, what has been done about the problem before, what are student, parent, and community attitudes. The definition of the problem should be written in a clear and concise statement which includes all data and details of each problem separately. This is needed to inform all players and reach consensus for a need to change. National groups, such as Pride, Inc. (Georgia State University) and Schlessinger Foundation, both of Atlanta, Georgia, have surveys that can be purchased. Check with your State Department of Education. It may have a questionnaire strategy that could be followed.
2. Develop through discussion and consensus, a perceived need and concern for implementing prevention efforts are developed within the school. As presented

in Chapter Five, this is done through individual discussions with teachers and administrators whenever the opportunity presents itself. Of critical importance is to obtain the school principal's support and more than half of the school staff perceiving a need for prevention services.

3. Provide, as discussed in Chapter Four, teacher/staff/ community in-service training as needed during each of these steps.
4. Establish a School Impact Team. This group, of no more than seven members, provides the means for change within the school and community involvement in support of it. This team, referred to in Chapter Five as the school prevention team, will need the sanction of the principal and his/her commitment to endorse and provide resources to implement their findings and plans for change. This team will assist in planning, implementing, and further evaluating a drug abuse prevention program which addresses the four necessary components. It will establish prevention goals, objectives, and strategies based on an assessment of school needs for ongoing community input when necessary. It will serve as a monitoring and evaluation group, periodically reviewing and evaluating the prevention program to determine the extent to which it is meeting its goals and objectives.
5. Design the prevention program to be unique to each individual school setting. Program design needs to include the following:
    a. Teacher and Staff In-Service Training in Communication Skill —Substance abuse prevention training should be provided on an ongoing basis to all school personnel and should include information on policies and procedures, identification and referral procedures, and progress in implementing the school prevention program. Ongoing clarification of each individual's role in helping insure the success of the program is needed. Training

specific to teachers will emphasize how to select and implement a prevention curriculum and formulate classroom and intervention strategies for working with young people.

In-service training should help school personnel become knowledgeable about substance abuse, clarify their own values and beliefs about the problem, and learn appropriate teaching techniques related to the K-12 prevention curriculum they select. Of equal or greater importance is that teachers learn the importance of being able to present themselves in a caring manner to their students, offer support to them when necessary, and make appropriate referrals to school/community resources. Training topics include drugs, prevention, abused drugs, and recognition of drug abuse.

b. A K-12 Curriculum–The classroom curriculum to use from kindergarten through 12th grade must be decided upon by the teachers. Hundreds of such curricula exist so selection would be based on local preference but should include the components addressed in Chapter Three. A good strategy for evaluating curricula is provided in Moore, et al (1991), *Preparing Tomorrow's Teachers in Substance Abuse Prevention: A Curriculum for Teacher Education.* Additional guidance is provided by Bailey (2003) who summarizes research evaluation evidence on forty-seven school based drug abuse prevention curricula. He reports that only six curricula, (Life Skills Training, STAR/I-STAR – Students Taught Awareness and Resistance, Seattle Social Development Program, Project Northland, Alcohol Misuse Prevention Program and Teenage Health Teaching Modules), demonstrate credible evidence of effectiveness evaluation. He also provides web links for each. The first three of these curricula also have been identified by The

National Institute on Drug Abuse as effective, research based prevention programs.

The curriculum selected by teachers with assistance from the School Impact Team should emphasize avoidance skills, health promotion, personal competency, and responsibility. One of the best prevention strategies for teachers is to assist students to be successful. The curriculum, as discussed in Chapter Four, should provide for student skill development in:

1) communication skills;
2) problem solving;
3) management of stress and anxiety;
4) health and wellness; and
5) personal competence.

c. Student Extracurricular Activities—These include a drug-free climate characterized by supervised drug-free supportive school activities and clear policies and procedures. Support for students with need is provided through individual and group counseling, peer counseling, and a variety of Student Assistance Programs as discussed in Chapter Four. Additional information related to student extracurricular activities can be found at the CSAP (2003) PREVline Web site. The Center for Substance Abuse Prevention (CSAP) has an on-line prevention resource called PREVline (www.health:org). This site contains student extra-curricular activities, resources, and referral sources such as the National Clearinghouse for Alcohol and Drug Information (NCADI). NCADI (1-800-729-6686) has federal prevention publications available, usually at no cost. The site also connects to six regional Centers for the Application of Prevention Technologies (CAPT) in the United States that can be contacted for advise. Also, as noted earlier, state departments of education receive money from the federal Department of Education's Safe and Drug Free Schools Program and should be able to direct you to supportive prevention programs and staff in your local area that can provide assistance.

   d. Family-Community Involvement—This involvement should be very active and supportive of school prevention efforts as discussed in Chapter Four. Additional information regarding strategies for involving family and community in school prevention efforts are provided by the IPRC (2003) web site links to "The Role of Parents" and "Community-based Prevention."

6. Define Prevention Objectives. The objectives should be specific to the problems identified. The desired outcomes should also be operationalized in terms of goals and objectives related to the number of problems identified. Again, while general goals and objectives can be generally addressed within the curriculum, goals and objectives in extra-curricular areas need to be very specific. By way of example, the types of prevention objectives that could relate to an alcohol problem might be "In cooperation with parents, deter unsupervised parties" or "Insure no drinking occurs at school-sponsored events." Objectives must be written for each problem area. It is necessary to be clear and precise in identifying the activity to be accomplished or outcomes to be expected.
7. Select Appropriate Strategies. These should be specific and must be implemented in the following areas:
   a. Implementation of a prevention curriculum which is comprehensive in terms of prevention skills and taught K - 12. The curriculum, as noted in Chapter Four, should develop personal competence and skill development, convey an anti-drug theme, and target "gateway" drug use - alcohol, cigarettes, and marijuana.
   b. Use of a teaching style which is responsive to the individual and respectful of individual differences. This style should facilitate personal as well as cognitive development and be characterized by the ability to:

        1) communicate effectively;
        2) value each student as an individual;
        3) motivate positively;
        4) develop competence in youth;
        5) develop a positive learning environment;
        6) serve as a role model; and
        7) work as a team member to affect change in schools.

    c. Creation of a school climate which insures a drug-free attitude, supported by example. School personnel should serve as role models. Student assistance programs and peer counselors are examples of supportive peer activities. Accountability should be at school level, not just the class level, and be characterized by:
        1) clear policies and procedures;
        2) fair administration;
        3) peer-to-peer supportive relationships;
        4) prevention-oriented extra-curricular programming; and
        5) supportive community.

    d. Support of family and community obtained through collaboration so that they will invest in and support prevention efforts. A prerequisite for this is a process of determining attitudes, educating, and exploring cooperative efforts with family and community resources. In a comprehensive prevention program, family and community members are:
        1) viewed as partners;
        2) supportive of prevention goals; and
        3) participating in school goal efforts.

8. Implement the Program. As designed, programs will be unique to each individual school.
9. Evaluate and Adjust. Evaluate the program for strengths and weaknesses and make needed adjustments.

While the above steps seem simple, as noted in Chapter Five, they are in fact complex and attainment of them requires a major time commitment on the part of everyone involved. However, the benefits of this commitment will be immeasurable. Implementing prevention programming in schools can prevent what are now tragedies in thousands of young people's lives.

References

Adair, J. (2000).Tackling teens' No. 1 problem. *Educational Leadership, 57*(6), 44-47.

Adams, D., & Hamm, M. (1994). *New designs for teaching and learning: Promoting active learning in tomorrow's schools.* San Francisco: Josey-Bass.

Amaro, H., Blake, S. M., Schwartz, P. M., & Flinchbaugh, L. J. (2001, August). Developing theory based substance abuse prevention programs for young adolescent girls. *Journal of EarlyAdolescence, 21*(3), 256-93.

American Federation of Teachers. (2000). *Early estimates of public elementary and secondary education statistics, 1999-2000.* U.S. Department of Education, Washington, D.C: Author.

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders - technical revisions.* (4th ed.). Washington, D.C: Author.

American School Counselor's Association. (2003). *The ASCA National Model: A framework for school counseling programs.* Alexandria, VA: American School Counselor Association.

Apgar, B. (1998). Antisocial personality and substance abuse. *American Family Physician, 58*(6), 1418-1420.

Arnold, M.S. (1995). Exploding the myths: African-American families at promise. In B. B. Swadener & S. Lubeck (Eds.) *Children and families at promise* (pp. 143-162). Albany, NY: State University of New York Press.

Austin, L. (1999). *The counseling primer.* Philadelphia, PA: Accelerated Development.

Authenelli, R.M. & Schuckit, M.A. (1997). Genetics. In Lowinson, J.H., Ruiz, P., Millman, R.G., Langrod, J.G. (Eds.), *Substance abuse* (3rd ed.), (pp. 319-330). Baltimore, MD: Williams & Wilkins.

Bailey, William J. (2003) *Effective drug prevention curriculum for schools*. Retrieved from September 16, 2003 from the World Wide Web site: http://www.drugsindiana.edu/prevention/prevention_curriculum.html.

Baker, S.B. & Shaw, M.D. (1987). *Improving counseling through primary prevention.* Columbus, Ohio: Merrill Publishing Company.

Beck, R., Marr, K. & Taricone, P. (1998). Identifying and treating clients with physical disabilities who have substance abuse problems. *Rehabilitation Education, 5,* 131-138.

Berliner, D.C. & Biddle, B.J. (1995). *The manufactured crisis: Myths, fraud, and the attack on America's public schools.* Reading,MA: Addison-Wesley.

Blume, S.B. (1997). Pathological gambling. In Lowinson, J.H., Ruiz, P., Millman, R.B., Langrod, J.G. (Eds). *Substance Abuse* (3rd ed.), (pp. 330-337). Baltimore, MD: Williams & Wilkins.

Botvin, G.J. & Golona, E.M. (1997). School based programs. In J.H. Lowinson, P. Ruiz, R.B

Millman, J.G. Langrod. (Eds.), *Substance Abuse* (3rd ed.), (pp.764-775), Baltimore, MD: Williams & Wilkins.

Brown, D. (1999). *Proven strategies for improving learning and achievement.* Greensboro, NC: CAPS Publications.

Brown, K. J. & Block, A. J. (2001, August). Evaluation of project Chrysalis: A school-based intervention to reduce negative consequences of abuse. *Journal of early adolescence, 21,* (3), 325-53.

Buck, E. & Sales, A. (2000). Related addictive behavior. In A. Sales (Ed.) *Substance abuse and counseling* (pp 55-74). Greensboro, NC: CAPS, Inc.

Buncher, R.M. (1997, April). The replicability and transferability of a school-based substance abuse prevention program to a community-based setting. *Dissertation Abstracts International: Section-B: The Sciences and Engineering, 57* (10-B): 6559.

Burns, T.E. (1994). *From risk to resiliency*. Dallas, TX: Marco Polo Publishers.

Burt, M.R., Resnick, G., & Novick, E.R. (1998). *Building supportive communities for at-risk adolescents.* Washington, D.C.:APA.

Bushweller, K. (1995a). What makes resilience? *The Education Digest, 61*(3), 15.

Bushweller, K. (1995b). The resilient child. *The American School Board Journal, 5*,18-23.

Caplan, H. (1964). *Principles of preventive psychiatry*, New York, NY: Basic Books.

Center for Disease Control and Prevention. (1994). *HIV/AIDS: surveillance report*, 6, (2), 139, Washington, D.C: U. S. Government Printing Office.

Charney, R.S. & Clayton, M.K. (1994). The first 6 weeks of school. *The Responsive Classroom, 6*(2),1-3.

Chen, K. & Kandel, D.B. (1995, January). The natural history of drug use from adolescence to the midthirties in a general population sample. *American Journal of Public Health, 85* (1),41.

Cobb, N. K. (1994). *The future of education: Perspectives on national standards for America.* New York: College Entrance Examination Board.

Cohen, S.B. & de Bettencourt, L.V. (1991). Dropout: Intervening with the reluctant learner. *Intervention in School and Clinic, 26,* 263-271.

Coker, J. K. (2001, March). Four-fold prevention: Strategies to prevent substance abuse among elementary school-aged children. *Professional School Counseling, 5*(1), 70-74.

Commer, J.P. (1996). *Rallying the whole village: The Commer process for reforming education* .New York, NY: Teachers College Press.

Connecticut Clearinghouse. (1998). *Substance abuse prevention and disability.* Retrieved April 20, 2003 from the World Wide Web site: http://@clearinghouse.org.fpreodis.hnt.hmt.

Cosden, M. (2001, July/August). Risk and resilience for substance abuse among adolescents and adults with LD. *Journal of Learning Disabilities, 34(*4), 352-358.

Center for Substance Abuse Prevention. (1991). *The future by design: A community framework for preventing alcohol and other drug problems through a systems approach.* Washington, D.C: U.S. Government Printing Office.

Center for Substance Abuse Prevention. (1993). *Frequently asked questions about preventing alcohol, tobacco, and other drug problems.* Washington, D.C.: U.S. Government Printing Office.

CSAP. (2003). Center for Substance Abuse Prevention's PREVline Web site. Retrieved September 16, 2003 from the World Wide Web site: http://www.health.org.

Donovan, P. (1993). *Testing positive: Sexually transmitted disease and the public health response.* New York, NY: The Alan Guttmacher Institute.

Durak, J.A. (1995). *School-based prevention programs for children and adolescents.* Thousand Oaks, CA: Sage.

Elmore, R., Peterson, P.L., & McCarthey, S. (1996). *Restructuring in the classroom: Teaching, learning, and school organization.* San Francisco, CA: Josey-Bass.

English, R. W. (2000). Working with families affected by substance abuse. In A.Sales (Ed.), *Substance abuse and counseling* (pp.177-214). Greensboro, NC: CAPS Inc.

Erhard, Rachel. (1999). Peer-led and adult-led programs: Student perceptions. *Journal of Drug Education, 29*(4), 295-308.

Erickson, H. L. (1998). *Concept-based curriculum and teaching: Teaching beyond the facts.* Thousand Oaks, CA: Corwin Press.

Falco, M. (1992). *The making of drug-free America: Programs that work.* New York: NY: New York Times Books.

Fenstermacher, G. (1986). Philosophy on research in teaching: Three aspects. In M. Wittrock (Ed.), *Handbook of research on teaching* (pp 37-49). New York, NY: McMillan.

Fisher, G.L. & Harrison, T.C. (2000). *Substance abuse: Implications for social workers, therapists, and counselors.* Boston, MA: Allyn & Bacon.

Ford, J. & Moore, D. (1992). *Substance abuse resources and disability issues, Training manual.* Dayton, OH: Wright State University School of Medicine.

Gerstein, D.R. & Harwood, H.J. (Eds). (1992). *Treating drug problems* (Vol.2). Washington, D.C.: National Academy Press.

Glasser, W. (1990). *The quality school.* Phi Delta Kappan, *72*, 425-435.

Gold, M.S. & Miller, N.S. (1997). Cocaine (and crack): Clinical aspects. In J.H. Lowinson, E. Ruiz, R..B. McMilman, & J. F. Langord (Eds.), *Substance abuse: A comprehensive textbook* (3rd ed.), Baltimore, MA: Williams & Watkins.

Greenfield, L., Finkbiner, R., & Bishop, S. (2000). *The effect of substance abuse treatment on high risk behaviors, National treatment evaluation study.* Fairfax, VA: Caliber Associates.

Grinspoon, L. & Bakalar, J.B. (1993). *Marijuana, the forbidden medicine.* New Haven, CT: Yale University Press.

Grube, J.W. & Wallack, L. (1994). Television beer advertising and drinking knowledge, beliefs, and intentions among school children. *American Journal of Public Health: 84*(2), 254-259.

Gysbers, N.C. & Henderson, P. (2001). *Developing and managing a school guidance program* (3rd ed.). Alexander, VA: American Counseling Association.

Haggerty, R.J., Sherrod, L.R., Garmezy, N. & Rutter, M. (1996). *Stress, risk, and resilience in children and adolescents: Process, mechanisms, and interventions.* New York, NY: Cambridge University Press.

Hansen, W.B. & Graham, J.W. (1991). Preventing alcohol, marijuana, and cigarette use among adolescents: Peer pressure resistance training versus establishing conservative norms. *Preventive Medicine, 20*, 414-430.

Hawkins, J.D., Catalano, R.F., & Miller, B. (1992). *Communities that care: Action for drug abuse.* San Francisco, CA: Jossey-Bass Publisher.

Hazelden Corporation. (1996). *Alcoholism and drug abuse: A growing problem with the elderly.* Retrieved August 10, 2002, from the World Wide Web site: http//:www.ericcass.uncg.edu/virtuallib/subabuse/1083.htm

Hoffman, J., Brittingham, A., & Larison, C. (1996). *Drug use among U.S. workers: Prevalence and trends by occupation and industry categories.* Washington, D.C.: Substance Abuse and Mental Health Services Administration.

Hogue, A.T., Liddle, H. A., Becker, D., & Johnson-Leckrone, J. (2002). Family-based prevention counseling for high-risk young adolescents: Immediate outcomes. *Journal of Community Psychology, 30*(1), 1-22.

Horn, K. & Kolbo, J. R. (2000). Application of a cumulative strategies model for drug abuse prevention: Exploring choices for high risk children. *Journal of Drug Education, 30*(3), 291-312.

Inaba, D.S. & Cohen, W.E. (2000). *Uppers, downers, and all-arounders: Physical and mental effects of psychoactive drugs.* (4th ed.). Ashland, OR: CNS Publication, Inc.

IPRC. (2003). Indiana Prevention Resource Center. Retrieved September 16, 2003 from the World Wide Website: http: //www.drugs.indiana,edu/prevention/.

Jansen, M.A., Glynn, T., & Howard, J. (1996). Prevention of alcohol, tobacco, and other drug abuse: Federal attempts to stimulate prevention research. *American Behavioral Scientist, 39,* 790-807.

Jessor, R. (1993). Successful adolescent development among youth in high-risk settings. *The American Psychologist, 48*(21), 117-126.

Join Together. (2000a). *Youth prevention. Technical assistance packet.* Retrieved September 1, 2002, from World Wide Web site: http: //www.jointogether.org

Join Together. (2000b). *How communities can strengthen their strategies to fight drug abuse using research from the National Institute on Drug Abuse.* Retrieved September 2, 2002, from World Wide Web site: http//www.jointogether.org/sa/files/pdf/ nida2000.pdf.

Jones, R., Kline, K., Habkirk, S., & Sales, A. (1990). Teacher characteristics and competencies related to substance abuse prevention. *Journal of Drug Education, 20*(3), 179-189.

Kandel, D.B. & Davies, M. (1996). High school students who use crack and other drugs. *Archives of General Psychiatry, 53*, 71-80.

Kozol, J. (1991). *Savage inequalities: Children in America's schools* (1st ed.). New York, NY: Crown Publications.

Lane, P.S. & McWhirter, J.J. (1996). Creating a peaceful school community: Reconciliation operationalized. *Catholic School Studies, 69*(2), 31-34.

Lee, C.C. & Walz, G.R. (1998). *Social action: A mandate for counselors.* Alexandria, VA: American Counseling Association.

Lettieri, D. J., Nelson & Sayers, M. (1985). *Program planning and evaluation.* National Institute on Alcohol Abuse and Alcoholism, U.S. Department of Health and Human Services, Washington D.C.: U. S. Government Printing Office.

Lewis, J. & Bradley, L. (Eds.). (2000). *Advocacy in counseling: Counselors, clients and community.* Greensboro, NC: CAPS Publications.

Lilienfeld, D.E., Stolley, P.D. & Lilienfeld, A.M. (1994). *Foundations of epidemiology* (3rd ed.). Oxford: University Press.

Loftquist, W.A. (1983). *Discovering the meaning of prevention.* Tucson, AZ: AYD Press.

Madden, P.A. & Grube, J.W. (1994). The frequency and nature of alcohol and tobacco advertising in television sports, 1990 through 1992. *American Journal of Public Health, 84,* 297-299.

Marsiglia, F. F., Holleran, L, & Jackson, K. M. (2000). Assessing the effect of external resources on school- based substance abuse prevention programs. *Social Work in Education, 22*(3), 145-162.

McWhirter, E.H. (1994). *Counseling for empowerment.* Alexandria, VA: American Counseling Association Press.

McWhirter, J.J., McWhirter, B.T., McWhirter, A.M., & McWhirter, E.H. (1998). *At-risk youth: A comprehensive response* (2nd ed.). Pacific Grove, CA: Brooks Cole.

Melton, A.P., Chino, M., May, P.A., & Gossage, J.P. (2000). *Promising practices and strategies to reduce alcohol and substance abuse among American Indians and Alaska Natives: An OJP issues & practices report.* Albuquerque, NM: American Indian Development Associates.

Monti, P. M., Colby, S. M., O'Leary, T.A., & Thomas, R. (2001). *Adolescents, alcohol, and substance abuse: Reaching teens through brief interventions.* New York, NY: Guilford Press.

Moore, S., Sales, A., & Fenstermacher, G.(Eds). (1991). *Preparing tomorrow's teachers in substance abuse education: A curriculum for teaching education.* Tucson,.AZ: University of Arizona Press.

Mosher, J.F. & Yanagisako, K.L. (1991). Public health, not social warfare: A public health approach to illegal drug policy. *Journal of Public Health Policy, 12*(3), 278-322.

Namyniuk, L., Brems, C., & Kuka-Hindin, C. (2001). Ethnic differences in substance use patterns in a sample of pregnant substance-using women in treatment. *Journal of Addictions and Offender Counseling, 21*(2), 50-67.

National Center on Addiction and Substance Abuse. (2000). *No place to hide: Substance abuse in mid-size cities and rural America.* Washington, DC: Drug Enforcement Administration.

National Institute of Alcohol Abuse and Alcoholism. (1994). *National alcohol program information system (NAPIS).* Rockville, MD: Author.

National Clearinghouse for Alcohol and Drug Information. (2001). Retrieved August 15, 2002 from World Wide Web site:http: //www.health.org/ kidsarea/funstuf/brain/inhal.htm.

Office of Substance Abuse Prevention. (2000). *A Promising Future: Alcohol and Other Drug Problem Prevention Services Improvement,* Prevention Monograph & 10, BK191. U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration. Washington, D.C.: U.S. Government Printing Office.

Pentz, M.A., Bonnie, R.V, & Shoplund, D.R. (1996). Integrating supply and demand reduction strategies for drug abuse prevention. *American Behavioral Scientist, 39*(7), 897-910.

Randolph, S.M. (1995). African-American children in single mother families. In B.J. Dickerson (Ed.), *African-American single-mothers:Understanding their lives and families* (pp.117-145). Thousand Oaks, CA: Sage Publication Inc.

Reid, C.& Kampfe, C. (2000). Multicultural issues. In A.Sales. (Ed.), *Substance abuse and counseling.* (pp. 215-246). Greensboro, NC: CAPS, Inc.

Reminger, K.A., Hidi, S., & Krapp , A. (1992). *The role of interest in learning and development*. Hillsdale, NJ: Erlbaum Associates.

Resnick, L.B., Saljo, R., Pontecorvo, C., & Burge, B. (1997). *Discourse, tools, and reasoning: Essays on situated cognition*. Berlin, NY: Springer.

Robert Wood Johnson Foundation. (1995). *Substance abuse report*. New York, NY: Author.

Sales, A. (1990). Integrating prevention concepts, skills, and practices into the teacher education curriculum (1990). *In Preparing tomorrow's teachers: A curriculum for teacher education*. Louisville, KY: Southeast Regional Center for Drug-Free Schools Training.

Sales, A. (2002) (Chp. 1) History of rehabilitation in the U.S.: Paternalism to empowerment. In J. Andrew & C. Faubron (Eds). *Rehabilitative services: An introduction for the human services professional.*(pp.1 –41). Osage Beach, MO: Aspen Professional Services.

Sales, A. (2000a). *Substance abuse and counseling: A perspective*. ERIC Digest, Greensboro, NC:ERIC Clearinghouse on Counseling and Student Services.

Sales, A. (2000b). Substance abuse and counseling: An introduction. In A. Sales, (Ed.). *Substance abuse and counseling*. (pp.1-20). Greensboro, NC: CAPS Inc.

Sales, A. (2000c). Substance abuse and disability. In A. Sales (Ed), *Substance abuse and counseling. (pp.247-273).* Greensboro, NC: CAPS Inc.

Schliebner, C. & Peregoy, J.J. (1998). Working with diverse culture: Treatment issues and characteristics. In P. Stevens-Smith, & R. Smith,Eds. *Substance abuse counseling: Theory and practice*. (pp. 219-240). Columbus, OH: Merrill.

Selzer, M. L., Vinokur, A., & Rooijen, L. (1975). A self-administered short Michigan alcoholism screening test (SMAST). *Journal of Studies on Alcohol*, *36*(1), 117-126.

Sexton, T.L., Whiston, S.C., Bleur, J.C. & Walz, G. (1997). *Integrating outcome research into practice*. Alexandria, VA: American Counseling Association.

Shapiro, E. S. & Cole, C.L. (1994). *Behavior change in the classroom*. New York, NY: Guilford Press.

Sharan, S. (1994). *Handbook of cooperative learning methods*. Westport, CT: Greenwood Press.

Shin, H. S. (2001). Continuing education - A review of school-based drug prevention program evaluations in the 1990s. *Journal of Health Education, 32*(3), 139-47.

Shoenborn, C.A. & Adams, P.F. (2001). *Alcohol abuse among adults: United States, 1997-1998*. Advance Data, Number 324, Washington, D.C.: National Center on Health Statistics.

Short, J. L. (1998). Evaluation of a substance abuse prevention and mental health promotion program for children of divorce. *Journal of Divorce and Remarriage, 28*(3-4), 139-157.

Slavin, R.E., Karweit, N.L., & Wasik, B.A. (1992). *Preventing early school failure: What works*. Boston, MA: Allyn and Bacon.

Stall, R. S. (1996). *Drug abuse in the elderly: Major issues*. Retrieved September 3, 2003, from the World Wide Web site: http://www.acsu.buffalo.edu/-drstall/drugqa.htm

Sussman, S., Dent, C.W., Stacy, A.W., Sun, P., Craig, S. & Simon, T.C. (1993). Project toward no tobacco use: 1-year behavior outcomes. *American Journal of Public Health, 83*, 1245-1250.

Tansy, M., de Barona, S.. McWhirter, J.J., & Herrman, D. S. (1996). Peer and cross age tutoring programs: Counselor contribution to student achievement. *Guidance and Counseling, 12*(1), 21-24.

U.S. Department of Justice. (2000). *Promising practices and strategies to reduce alcohol and substance abuse among American Indians and Alaska Natives.* Washington D.C: Author.

Vaughn, E. (1993). Chronic exposure to an environmental hazard: Risk perception and self-protective behavior. *Health Psychology, 12*, 74-85.

Vaughn, V.C. & Litt, L.S. (1990). *Child and adolescent development: Clinical implications.* Philadelphia, PA: W.B. Saunders Company.

Werner, E.E. (1995). Resilience in development. *Current Directions in Psychological Science, 4*(3), 81-82.

Westberg, J. (2001). Healthy nations: Communities create solutions for substance abuse. *Winds of Change, 16*(3), 38-43.

Wills, T.A., Schreibman, D., Benson, G., & Vaccara, P. (1994). Impact on parental use on adolescents: Test of a mediation model. *Journal of Pediatric Psychology, 19*, 537-555.

Wilson, J.Q. (1993). *The moral sense.* New York, NY: The Free Press.

Witmer, J. & Myrick, R.D. (1980). *Facilitative teaching: Theory and practice (2nd ed.).* Minneapolis: MN: Educational Media Corp.

World Almanac Books. (2000). *World Almanac and Book of Facts* (2000). Mahwak, NJ: Author.

Wright State University. (1996). *Substance abuse, disability, and vocational rehabilitation.* Rehabilitation Research and Training Center on Drugs and Disability. New York, NY: University Press.

Yalom, I. (1995). *The theory and practice of group psychotherapy* (4th ed.). New York, NY: Basic Books, Inc.

APPENDIX A

Common Drugs of Abuse

This summary list of common drugs of abuse includes customary methods of administration, general physiological consequences (short-term and long-term), and common slang terms for each.

Several factors determine an individual's response to a drug. These include how the drug is administered, its dosage, whether the drug is taken with another drug, and how quickly it is absorbed and metabolized; individual factors include a person's weight, age, sex, genetic predispositions, physical health, and mental health. Overdose of many of the following drugs can be fatal. All can harm infants of women who use them during pregnancy.

Alcohol

Alcohol is taken orally, and is absorbed into the bloodstream from the entire gastrointestinal tract, affecting the brain, heart, liver, stomach, pancreas, kidneys, and other parts of the body.

Short-term effects: increased heart rate and appetite; dilation of blood vessels; lowered blood pressure; depression of specific areas of the brain, producing lack of coordination, confusion, anesthesia, and coma.

Long-term effects: damage to the brain, heart, liver, pancreas, and nervous system; contributes to certain cancers and various forms of heart disease.

Slang names: booze, liquor, sauce, juice, medicine, moonshine, firewater, cocktails, highballs, nightcaps.

Amphetamines

These substances are taken orally in tables or capsules, by injection, or smoked or sniffed in powder form. They are absorbed through various parts of the body depending upon the other organs.

Short-term effects: alertness, mood elevation; increased heart rate, breathing rate, blood pressure; dilation of pupils; decreased appetite; dry mouth, sweating; headache, blurred vision, dizziness, and anxiety.

Long-term effects: hallucinations, delusions, and paranoia;

weight loss, vitamin deficiencies, and malnutrition; skin disorders; ulcers; tolerance and dependency.

Slang names: uppers, eye-openers, speed, ups, crystal meth, crystal, hearts, pep pills, ice, jelly beans, black beauties, crank, copilots.

Cocaine

Cocaine is typically sniffed (to inhale fumes), snorted (to inhale the drug in powdered form), smoked (as "crack"), and occasionally injected. Cocaine is absorbed through the mucous membranes in the nose, affecting the brain, lungs and heart.

Short-term effects: muscle relaxation, staggering gait, slow reflexes; sleepiness, slurred speech, disorientation, poor judgment; hangover.

Long-term effects: irritability, agitation, paranoia; nerve damage; impaired liver function; intensification of underlying emotional problems; tolerance and dependency.

Slang names: barbs, blue devils, candy, downers, good balls, reds, red devils, yellows, yellow jacket, pinks, xmas trees, peanuts, ludes, tranks, downs.

Heroin and other opioids

Opioids are a class of drugs that include opium, morphine, codeine, heroin, and methadone. These drugs are absorbed poorly when taken by mouth, so they are usually snorted or injected, although some users inhale fumes off a piece of heated tinfoil. Heroin most easily crosses the blood-brain barrier.

Short-term effects: euphoria; pain relief; drowsiness; mood changes; confusion; respiratory depression; dizziness, decreased appetite.

Long-term effects: reduced production of male hormones; vitamin deficiencies, anemia, malnutrition; constipation; indifference to personal hygiene; vulnerability to infection and disease; tolerance and dependence.

Slang names: big H, horse, junk, black tar, brown tar, smack, hard stuff, brown sugar, mud, snow, harry, joy powder, skag, white horse, white stuff, school boy.

Inhalants (solvents, aerosols, and glue)

Inhalants pass without delay through the membranes of the lungs and are quickly absorbed into the bloodstream affecting the brain, lungs, liver, and kidneys.

Short-term effects: euphoria, dizziness, hallucinations; sneezing and coughing; sensitivity to light; nausea; central nervous system (CNS) depression (early stages include blurred vision, headache, skin pallor; medium stages includes drowsiness, incoordination, slurred speech; late stages include seizures, delirium, unconsciousness).

Long-term effects: fatigue; electrolyte (salt) imbalance; nosebleeds; bloodshot eyes; halitosis; facial sores; forgetfulness; tremors; depression, hostility, paranoia; damage to liver, kidneys, and bone marrow.

Slang names: poppers, snappers, glue, laughing gas, locker room, rush, whippets, bullet, bolt.

LSD (lysergic acid diethylamide)

LSD is usually applied in tiny amounts to surfaces that can be licked or ingested such as sugar cubes, small flakes of gelatin, or postage stamps. It is sometimes available in small tablets, capsules, or powder form.

Short-term effects: enlarged pupils; rapid heartbeat, shakiness, rising blood pressure, elevated body temperature, chills and sweats; diminished appetite, nausea; perceptual distortions and hallucinations ranging in nature from pleasurable to terrifying.

Long-term effects: agitation, insomnia, hallucinatory flashbacks after discontinuing use.

Slang names: acid, sugar, fry, window pane, royal blue, heavenly blue, wedding bells, pearly gates.

Marijuana

Marijuana is smoked or taken orally in some foods or beverages and is absorbed by most tissues and organs in the body, finding its way to fat tissues such as those in the brain and reproductive organs. Marijuana predominately affects the brain, lungs, and heart *Short-term effects*: increased heart rate; red eyes; euphoria, reflectiveness, disorientation, sleepiness, lack of coordination; respiratory irritation; memory impairment; increased appetite.

Long-term effects: lung damage; lack of energy and motivation; diminished immune response; accumulation in fatty tissues; impaired learning ability; psychological dependence; paranoia.

Slang names: pot, grass, weed, mary jane, dope, acapulco gold, thai sticks, hemp, reefer, joint, stick, lock weed.

Nicotine

Nicotine is smoked, inhaled, or chewed and subsequently is absorbed through the oral and basal mucous membranes and lungs. It affects the lungs, heart, brain, pancreas, kidneys, bladder, and other organs.

Short-term effects: increased heart rate, blood pressure; stomach acidity; bad breath; reduced sense of taste and smell; decreased skin temperature; stimulation followed by depression of brain and nervous system activity; decreased appetite; diminished physical endurance.

Long-term effects: addiction; chronic bronchitis, emphysema, and other lung diseases; heart disease, stroke; cancers of the lung, larynx, oral cavity, and esophagus; contributes to ulcer disease and cancers of bladder and pancreas; contributes to destruction of gums and discoloration and loss of teeth.

Slang names: smoke, cigs, cancer stick, fag (British term), chew, snuff.

PCP (phencyclidine)

PCP is sold in tablets and capsules, but is more frequently seen in a powder or liquid form that is applied to a leafy material (parsley, mint, oregano, marijuana) and smoked. PCP waned in popularity among young people during most of the 1980s, but beginning in 1989 its use increased again.

Short-term effects: sense of detachment from surrounding environment; numbness; slurred speech; loss of coordination, exaggerated body movements; rapid involuntary eye movements; nausea; elevated blood pressure; auditory hallucinations; sense of strength and invulnerability.

Long-term effects: anxiety; severe depression; violent

outbursts; social isolation; schizophrenia-like symptoms; possible irreversible psychosis.
Slang names: angle dust, lovely, hog, killer weed, loveboat.

Reprinted from Moore, S., Sales, A., & Fenstermacher, G. (Eds.) (1991). *Preparing Tomorrow's Teachers in Substance Abuse Prevention: A curriculum for teacher education.* Tucson, AZ: University of Arizona Press.

APPENDIX B

Effects of Individual Drugs

Alcohol (depressant)

Alcohol consumption causes a number of marked changes in behavior and impairs judgment and coordination. Signs and symptoms of use include: dilation of blood vessels; lowered blood pressure; lack of coordination; reduced reaction time; and confusion. At the lowest blood levels, the reticular system (a system of numerous large and small neurons and fibers scattered throughout the midbrain, pons, medulla, hypothalamus, and thalamus) begins to malfunction. This disruption interferes with regulation of the cerebral cortex, compromising its integrational and inhibitory ability. Complex, abstract, and poorly learned behaviors are also affected. Moderate to high doses markedly impair higher mental functions, severely altering a person's ability to learn and remember information. At very high doses, alcohol can cause respiratory depression and death.

With continual use, the risk for permanent brain damage increases. In studies comparing brains of rats fed alcohol chronically and in aging rats, findings demonstrate almost identical nervous and cerebrovascular changes, suggesting that chronic alcoholism may accelerate the processes associated with biological aging. Chronic brain injury caused by alcohol is second only to Alzheimer's disease as a known cause of mental deterioration in adults. Many symptoms, such as loss of ability to think abstractly, difficulty with speech, and decreased coordination, are similar in the two types of diseases. Both groups of patients exhibit brain atrophy (shrinkage) and similar abnormalities in brain electrical functioning. One significant difference, however, is that Alzheimer's disease is invariably progressive, whereas alcohol-related mental deterioration can be arrested if alcohol use stops. Lastly, chronic alcohol use has been associated with enlargement of the ventricles and the space between folds in brain tissue.

Amphetamines/methamphetamines (stimulants)

The effects of amphetamines and methamphetamines are in many ways like those of cocaine (to follow in alphabetical order).

Amphetamine/methamphetamine effects usually are slower to appear and last longer than cocaine. Both produce euphoria, disappearance of fatigue, and feelings of enhanced physical strength and mental capacity.

In studies with normal volunteers, low doses of amphetamines/methamphetamines produced elation, increased vigor, arousal, and improved mood; repeated administration, however, adversely affected mood. Conversely, users have reported fright, sensory distortions, hallucinations, chills or sweating, nausea, vomiting, jaw clenching, flushing, increased blood pressure, enlarged pupils, liver problems, impaired balance, and loss of coordination. Other initial physical effects include: increased heart rate, respiratory rate, blurred vision, dizziness, insomnia, anxiety, cardiac irregularities, and loss of weight and appetite. These drugs initially stimulate, then reduce, activity in the brain and central nervous system (CNS). In animals, amphetamines stimulate the medullary respiratory center, reticular activating system (RAS) and cerebral cortex. Such stimulation may lead to lasting symptoms, such as paranoid psychosis in which the user becomes very frightened and out of touch with reality.

Long-term effects of these substances can include hallucinations, delusions, paranoia, depression, and brain damage. Overdose from amphetamines and methamphetamines may cause convulsions, coma, and death.

Caffeine and nicotine (stimulants)

The main pharmacological actions of caffeine are exerted on the central nervous system (CNS), heart, kidneys, lungs, and arteries supplying blood to the heart and brain. Caffeine is a powerful stimulant of nerve tissue in the brain. The cortex, being most sensitive, is affected first, followed next by the brain stem. The spinal cord is stimulated last, but only after extremely high doses of caffeine. Heavy consumption (12 or more caffeine-containing beverages a day) can cause more intense effects of agitation, anxiety, tremors, rapid breathing, and cardiac arrhythmias. Excessive doses of caffeine can result in restlessness, depression, increased motor activity, agitation, and hallucinations. Studies raise concern that an association exists between caffeine intake and the incidence of heart attack and increased blood levels of cholesterol.

Like PCP (phencyclidine), nicotine acts as both a stimulant and a depressant. It can increase respiration, heart rate, and blood pressure while decreasing appetite. Like caffeine, short-term effects of nicotine lead to increased heart rate and blood pressure, with initial stimulation, then reduction, of brain and central nervous system (CNS) activity. Nicotine intoxication is characterized by euphoria, lightheadedness, dizziness, and elevated heartbeat and respiration. The long-term damage from nicotine use has been widely publicized; regular cigarette smoking is a leading cause of serious diseases of the lungs, heart, and blood vessels. Tobacco use is widely acknowledged as the leading cause of preventable death in the U.S.

Nicotine is a highly addictive drug that may leave some users with a residual nicotine craving, or drug hunger, for life. While use of nicotine among young people generally is not viewed with the same alarm as other drugs, it continues to be a "gateway drug" for many. Adolescents who only smoked cigarettes were significantly more likely to be using other drugs within two years than those who didn't.

Cocaine (stimulants)

Cocaine stimulates at least two sections of the brain: the cerebral cortex (responsible for memory and reasoning), and the hypothalamus (regulates appetite, body temperature, sleep, and certain emotional reactions). Physical signs and symptoms of use include dilated pupils, sweating, constricted blood vessels, increased heart rate and/or palpitations, increased breathing rate and body temperature, and elevated blood pressure.

The extreme euphoria associated with cocaine use mimics that produced by direct electrical stimulation of the "reward centers" of the brain. Repeated cocaine use upsets the delicate balance of three neurotransmitters (norepinephrine, epinephrine, and dopamine). These chemical messengers function as natural stimulants to the brain. Cocaine causes brain cells to release their supplies of all three, but blocks the brain's normal re-uptake of the neurotransmitters after release, leading to an eventual exhaustion of the natural supply. After constant use, the brain craves this stimulation, progressing to the mental torment associated with cocaine withdrawal.

The first perceptible behavioral change is a loosening of emotional restraint accompanied by a feeling of pleasure. Shortly thereafter, the positive mood intensifies to euphoria and elation. Low doses increase alertness, talkativeness, and feelings of power and energy; they decrease appetite and desire for sleep, sometimes causing anxiety and agitation. Larger doses are associated with impaired judgment, insomnia, irritability, anxiety, and tremors. Long-term or high-dose use leads to seizures, transient psychotic episodes, and paranoia. Acute cocaine poisoning causes profound stimulation of the central nervous system (CNS), progressing to convulsions and respiratory or cardiac arrest. In addition, there are very rare, severe, and unpredictable toxic reactions to cocaine and other local anesthetics in which individuals die rapidly, presumably from cardiac failure.

Depressants (including barbiturates and tranquilizers)

Depressants slow neurochemical activity in the central nervous system (CNS). Observable signs of use include: muscle relaxation; calmness; slurred speech; staggering gait; impaired judgment; and slow reflexes. The progression of effects begins with relief from anxiety advancing to suppression of inhibitions and then calmness. Sleep occurs with high doses, and large doses of certain types of barbiturates can produce general anesthesia. Disinhibition (lack of or decreased inhibitions) arises from the suppression of the self-control mechanisms in the cortex and the release of impulses from the lower parts of the brain. This action is also responsible for the drunken euphoria and mood swings characteristic of users. In addition to depression of brain and nerve activity, depressants act similarly on the muscles and heart. They reduce metabolic rate in a variety of tissues and physical systems that use energy as a source of fuel. In normal doses, the sedative-hypnotic compounds appear to be selective in depressing certain (CNS) pathways affecting wakefulness. The depression of synaptic transmissions with these pathways explains the various stages of behavioral depression caused by these drugs. A depressant overdose can lower blood pressure and breathing rate, causing coma or respiratory failure and death.

Inhalants (including solvents, aerosols, and glue)

When inhalants are used, vapors pass directly from the lungs into the bloodstream and on to the brain. Short-term effects usually occur in a chain reaction that begins with feelings similar to alcohol intoxication, followed by brief euphoria lasting from a few minutes to an hour, with sensations of excitement and delusions of strength and power. Inhalants such as nitrites trigger a quick drop in blood pressure and a rapid heartbeat that shuts off oxygen to the inner brain. Observable signs include: dizziness, hallucinations, sneezing and coughing, sensitivity to light, nausea, early central nervous system (CNS) depression (disorientation, blurred vision, headache, skin pallor). Medium CNS depression typically follows, including drowsiness, incoordination, and slurred speech, progressing to late CNS depression (seizures, delirium, unconsciousness). Long-term effects produce fatigue, electrolyte (salt) imbalance, forgetfulness, tremors, depression, hostility, paranoia, potential damage to the liver, kidneys, blood, and bone marrow.

Marijuana

Cannabis (the technical name for marijuana) has stimulant, sedative, and hallucinogenic effects on the brain and the body. Absorption of delta-9-tetrahydrocannabinol (commonly known as THC) from the lungs to bloodstream to brain varies, but the average experienced user will absorb into the bloodstream approximately half the ingested dose. Effects are felt almost immediately and reach peak intensity within 30 minutes. The speed of onset is partially determined by the THC concentration. When smoked, the drug increases heart rate and lowers blood pressure, and causes reddening of the eyes.

The effects of low to moderate doses last two to six hours and range from relaxation, euphoria, talkativeness, and gaiety to mild fatigue, perceptual changes, lack of coordination, and feelings of heightened sensitivity. High or repeated doses can produce panic reactions in some users, reduced motivation, and distortions of body image. THC becomes concentrated in the body's fatty tissues and further lodges in the liver, lungs, reproductive organs, and brain.

By-products of the chemical breakdown of cannabis remain in the body for several weeks with unknown consequences. It can take three to seven days for the body to rid itself of half the THC in a single joint, and up to 30 days to eliminate completely all traces of the substance. Some THC can remain bound to proteins in the blood.

There is convincing evidence that cannabis produces acute chemical and electrophysiological changes in the brain. Changes in perception, reduced concentration, memory problems, and impaired judgment and coordination can linger up to 24 hours after use. Neurotransmitters in the area in the brain concerned with learning and short-term memory appear to be the most severely affected.

Some researchers attribute a personality change labeled *amotivational syndrome* to continued marijuana use. This syndrome consists of lack of energy, apathy, absence of ambition, loss of effectiveness, inability to carry out long-term plans, problems with concentration, shortened attention span, impaired memory, impeded communication skills, and a marked decline in school or work performance.

Evidence also suggests that chronic THC exposure damages and destroys nerve cells and causes other pathological changes in the brain. The loss of cells appears to be similar to the loss seen with normal aging, thus long-term marijuana users are at risk for serious or premature memory disorders as they age. These and other effects of cannabis use on memory and thought processing may create long-term problems in learning and social development for adolescent users.

Narcotics (including heroin)

By medical definition, narcotics are opium and opium derivatives or synthetic substitutes. Narcotics act by binding to receptor sites in the brain and digestive tract and stimulating physical reactions. Narcotics act on the central and parasympathetic nervous systems, slowing down body systems, reducing sensitivity to pain, and inducing sleep. Low doses produce euphoria, fatigue, analgesia, and impaired concentration, while eliminating the desire for food, sex, and most activity. They also can cause confusion and inability to concentrate. High doses suppress breathing and heart rate, leading to convulsions and death by respiratory failure. Symptoms of use are constriction of pupils, lack of responsiveness to pain, nausea or vomiting, lethargy, slow breathing, and alternating periods of wakefulness and sleep ("nodding off").

PCP and LSD (hallucinogens)

Hallucinogens, including phencyclidine (PCP) and lysergic acid diethylamide (LSD), act primarily on the central nervous system by interfering with the production and processing of chemical neurotransmitters in the brain. Effects can last anywhere from four to 12 hours or as long as 24 hours. Hallucinogens produce powerful changes in perception and thinking that are likened to a dream state. Young people who live on the border of reality through frequent drug-induced hallucinations, delusions or false alterations of emotions have little chance of achieving self-fulfillment.

PCP interrupts the functions of the neocortex, the area of the brain that controls instincts. Because the drug blocks pain receptors, violent PCP episodes may result in self-inflicted injuries. Time and body movement are slowed down. Muscular coordination worsens and senses are dulled. Speech is blocked and incoherent. A blank stare, rapid and involuntary eye movements, and an exaggerated gait are among the more common observable effects of PCP use. Chronic users of PCP report persistent memory problems, speech difficulties, and emotional and behavior problems, including extreme paranoia and increased aggression. Some of the effects may last six months to a year following prolonged daily use. Some researchers propose that long-term use of PCP is associated with damage to brain tissues, resulting in impaired thinking, memory loss, disorientation, and rapid mood swings, even when the user is not immediately under the influence of the drug. The question of permanent brain damage resulting from PCP use has not been settled.

Like PCP, LSD can produce mental changes by significantly disrupting normal brain processes due to LSD's close resemblance to the neurotransmitter serotonin. Common physical characteristics of LSD use are dilated pupils, hyperreflexia (exaggerated deep tendon reflexes), nausea, muscular weakness, increased heart rate, and an increase in blood pressure and body temperature. Unpleasant experiences with LSD are relatively frequent and can include confusion, dissociative reactions, acute panic reactions, and reliving of earlier traumatic experiences; in some cases, these reactions have been of an acute psychotic nature necessitating hospitalization.

Reprinted from Moore, S., Sales, A., & Fenstermacher, G. (Eds.) (1991). *Preparing tomorrow's teachers in substance abuse prevention: A curriculum for teacher education.* Tucson, AZ: University of Arizona Press.

APPENDIX C

Stages of Dependency and Addiction

1. First contact with the substance, person, or activity.
2. Feeling great pleasure with the substance, person, or activity.
3. Believing that the substance, person, or activity will improve one's life.
4. Not acknowledging the faults of the substance, person, or activity.
5. Friendships, former interests, work, or health suffer because of one's relationship with the substance, person, or activity.
6. Needing the substance, person, or activity to feel normal.
7. Denying that the substance, person, or activity is hurting one's life when other people point out the problems.
8. Feeling anxious, depressed, angry, or physically ill when the substance, person, or activity is not available.
9. Feeling miserable or uncomfortable when involved with the substance, person, or activity but not willing to let it or him/her go.

Reprinted from Moore, S., Sales, A., & Fenstermacher, G. (Eds.) (1991). *Preparing tomorrow's teachers in substance abuse prevention: A curriculum for teacher education*. Tucson, AZ: University of Arizona Press.

APPENDIX D

A Self-Administered Short Screening Test: (MAST)

The Michigan Alcoholism Screening Test (MAST) is probably the most widely used screening instrument to identify someone with an alcohol abuse problem. The MAST is a 25 item true/false test which asks specific questions about alcohol use and its impact on life situations. The following is a brief version of the MAST.

Brief MAST Questions

- Do you feel that you are a normal drinker?**
- Do friends or relatives think you are a normal drinker?**
- Have you ever attended a meeting of Alcoholics Anonymous?
- Have you ever lost friends or girlfriends/boyfriends because of drinking?
- Have you ever gotten into trouble at work because of drinking?
- Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?
- Have you ever had delirium tremens (DTs) severe shaking, heard voices, or seen things that weren't there after heavy drinking?
- Have you ever been in a hospital because of drinking?
- Have you ever been arrested for driving drunk?

Selzer, M. L., Vinokur, A., & Rooijens, L. (1973). A self-administered short Michigan alcoholism screening test.

APPENDIX E

SARDI Substance Abuse Symptoms Checklist

Exhibiting one of the symptoms below is not necessarily indicative of substance abuse; however, several or more of these symptoms in combination may suggest that issues related to substance abuse should be explored at greater length.

Frequent intoxication.

Does the person report or appear to be frequently high or intoxicated?

Do recreational activities center around drinking or other drug use, including getting, using and recovering from use?

Atypical social settings.

Does the immediate peer group of the individual suggest that substance abuse may be encouraged?

Is the person socially isolated from others and is substance abuse occurring alone?

Is the person reluctant to attend social events where chemicals won't be available?

Intentional heavy use.

Does the person use "social drugs" with prescribed medications?

Does the person use more than is safe in light of medications or compromised tolerance?

Does the person have an elevated tolerance as evidenced by the use of large quantities of alcohol or other drugs without appearing intoxicated?

Symptomatic drinking.

Are there predictable patterns of use which are well known to others?

Is there a reliance on chemicals to cope with stress?

Has the person made lifestyle changes yet the drug use has stayed the same or increased (e.g., changed friends or moved to another area)?

Psychological dependence.

Does the person rely on drugs as a means of coping with negative emotions?

Does the person believe that pain can't be coped without medication?

Does the person obviously feel guilty about some aspects of the use of alcohol or other drugs?

Health problems.

Are there medical conditions which decrease tolerance or increase the risk of substance abuse problems?

Are there recurring bladder infections, chronic infections, bed sores, seizures, or other medical situations which are aggravated by repeated alcohol or other drug use?

Did the disability occur when the individual was under the influence, even if it is denied by the person?

Job problems.

Is the person underemployed or unemployed?

Has the person missed work or gone to work late due to use of alcohol or other drugs?

Does the person blame the disability for work-related problems?

Problems with significant others.

Has a family member or friend expressed concern about the person's use?

Have important relationships been lost or impaired due to chemical use?

Problems with law or authority.

Has the person been in trouble with authorities or arrested for any alcohol or drug-related offenses?

Have there been instances when the person could have been arrested but wasn't?

Does the person seem angry at "the system" and at authority figures in general?

Financial problems.

Is the person's spending money easily accounted for?

Does the person frequently miss making payments when they are due?

Belligerence.

Does the person appear angry or defensive but doesn't know why?

Is the person defensive or angry when confronted about chemical use?

Isolation.

Does increasing isolation suggest heavier substance use?

Is the person giving up or changing social and family activities in order to use?

"Handicapism."

Does the person focus on disability to the exclusion of other aspects of life?

Does the person blame the disability for what goes wrong?

Ford, J.A. & Moore, D. (1992). *Substance abuse resources and disability issues, training manual*. Dayton, OH: Wright State University School of Medicine

APPENDIX F

Twelve Steps

Original Twelve Steps of Alcholics Anonymous

1. We admitted we were powerless over alcohol; that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God *as we understood Him.*
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.
6. We are entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong, promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God *as we understood Him*, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as a result of these steps, we tried to carry this message to alcoholics. And to practice these principles in all our affairs.

TBI Version by William Peterman

1. Admit that if you drink and/or use drugs your life will be out of control. Admit that the use of substances after having had a traumatic brain injury will make your life unmanageable.
2. You start to believe that someone can help you put your life in order. This someone could be God, an AA group, counselor, sponsor, etc.

3. You decide to get help from others or God. You open yourself up.
4. You will make a complete list of the negative behaviors in your past and current behavior problems. You will also make a list of your positive behaviors.
5. Meet with someone you trust and discuss what you wrote in step 4.
6. Become ready to sincerely try to change your negative behaviors.
7. Ask God for the strength to be a responsible person with responsible behaviors.
8. Make a list of people your negative behaviors have affected. Be ready to apologize or make things right with them.
9. Contact these people. Apologize or make things right.
10. Continue to check yourself and your behaviors daily. Correct negative behaviors and improve them. If you hurt another person, apologize and make corrections.
11. Stop and think about how you are behaving several times each day. Are my behaviors positive? Am I being responsible? If not, ask for help. Reward yourself when you are able to behave in a positive and responsible fashion.
12. If you try to work these steps you will start to feel much better about yourself. Now it's your turn to help others do the same. Helping others will make you feel even better. Continue to work these steps on a daily basis.

Stephen Miller House Version of AA 12 Steps (for Individuals who are Deaf)

1. We believe that when we drank, alcohol controlled our lives.
2. We began to believe in a Higher Power that would help us think better.
3. We decided to open our lives to God as we understood Him.
4. With courage, we searched our past to see what was good in us and what should be changed.
5. We admitted to God, to ourselves, and to another person all the wrong things we had done.
6. We became ready for God to take away our defects.
7. We honestly asked God to take away our defects.

8. We made a list of all the people we hurt and wanted to make right the wrongs.
9. We tried to make right the wrong things we did but not when it would hurt another person.
10. We continued to search our lives and when we were wrong admitted it at that time.
11. According to the way we understand God, we prayed and meditated to have better contact with Him and asked that He give us strength and guidance.
12. Having a new understanding of ourselves because of the steps, we tried to help others by sharing what we learned and practice these ideas in all daily activities.

Reprinted from Moore, S., Sales, A., & Fenstermacher, G. (Eds.) (1991). *Preparing tomorrow's teachers in substance abuse prevention: A curriculum for teacher education.* Tucson, AZ: University of Arizona Press."

APPENDIX G

Substance Abuse Treatment Approaches

1. Methadone Maintenance
   - a. For dependence on narcotic analgesics
   - b. Out-patient
   - c. Long-term to life
   - d. Treatment focuses on medication; support services may be provided

2. Therapeutic Community
   - a. Residential; group centered
   - b. Long-term: 12-18 months
   - c. For individuals with negative social adjustments

3. Chemical Dependency Treatment
   - a. 28 days; Minnesota model; Hazeldon type
   - b. Intensive, highly structured, 3-6 week regimen
   - c. Develop and implement recovery plan

4. Out-Patient
   - a. Short-term to one year
   - b. Broad range of therapeutic approaches
   - c. Heterogeneous population

APPENDIX H

Assessment Instruments

- *Behavior Rating Scale* - Social, Employment, Economic, Legal, Drinking (Brandsma, Maultsky & Welsh, 1980): This instrument forms the basis for interviews performed both before treatment and in follow-up. Separate scales assess social functioning, employment, economic status, legal issues, and drinking behaviors and attitudes. The authors used the 64-item scale to follow up on problem drinkers who had completed outpatient treatment.

- *Alcohol Dependence Scale* (Horn, Skinner, Wanberg, & Foster, 1984): The ADS is a brief, self-administered instrument made up of 25 multiple-choice items. It was designed for use at intake and as a follow-up instrument to assess one aspect of treatment outcome. The scale measures such aspects of alcohol dependence as withdrawal symptoms, obsessive/compulsive drinking style, tolerance, and drink-seeking behavior.

- *Client Follow-Up Interview* (Kelso & Fillmore, 1984): This assessment tool is a structured interview that can be given at intake, discharge, and follow-up. The interview assesses client functioning in a number of areas, collecting information relating to psychological functioning, alcohol consumption, drug use, physical health, personality, treatment factors, social relationships, employment, legal problems, life events, attitudes, and coping responses.

- *Addictive Severity Index* (McLenna, Luborsky, Woody, & O'Brien, 1980): The ASI is a well-tested instrument that assesses seven separate areas: medical status, employment status, drug use, alcohol use, legal status, family/social relationships, and psychological status. Completion of the structured interview leads to severity ratings for each area, from 0 (no treatment necessary) to 9 (treatment needed to intervene in life-threatening situation). The ASI has been found suitable for repeated administration in follow-up.

- *Health and Daily Living Form* (Moos, Cronkite, Billings, & Finney, 1984): The HDL Form was developed for use in a longitudinal follow-up study of treatment outcome. The 200-item instrument is appropriate for administration by the client or the interviewer and assesses health-related functioning, social functioning and resources, family functioning and home environment, children's health and functioning, life-change events, coping responses, and family-level composite. This is one of the very few instruments that takes into account life circumstances and events outside of the treatment milieu. Moos and his colleagues have also developed more specialized scales dealing with family and work environments.

- *DUI Probation Follow-Up Project Life Activities Questionnaire* (National Highway Traffic Safety Administration, 1981): This questionnaire was designed for the purpose of following up with clients who had been seen subsequent to substance abuse violations. The information gathered through use of the interviewer-administered instrument can supplement related outcome criteria as recidivism and accident involvement. The questionnaire addresses areas such as living situations, employment, health, alcohol use, social factors, marriage, and lifestyle.

- *National Alcohol Program Information System (NAPIS)*, ATC Client Progress and Follow-up Form (National Institute on Alcohol Abuse and Alcoholism, 1979): The National Institute on Alcohol Abuse and Alcoholism developed this instrument for use as a six-month follow-up tool for clients who had been treated in NIAAA-funded alcoholism-treatment centers (ATCs). It provides a good example of a general follow-up instrument, including questions related to marital status, employment financial support, household drinking, motor-vehicle records, institutionalization, drinking behaviors, and client self-perceptions.

- *ATC Follow-up Study Questionnaire* (Ruggles, Armor, Polich, Mothershead, & Stephen, 1975): This questionnaire was developed for the purpose of conducting 18-month follow-up interviews of clients treated in NIAAA-funded alcohol treatment centers. The assessment covers a variety of areas, including family situation, employment, alcohol consumption and problems, treatment history, legal issues, and perceptions of drinking problems.

- *Time-Line Follow-Back Assessment Method* (M.B. Sobell, et al, 1980): This assessment method provides a model that may be ideal for gathering information about drinking behavior as a continuous variable. An interview is used to gather reports of daily drinking behavior as clients remember it having occurred over a specific period. A blank calendar is filled in, with codes identifying each day as follows:

    - A: abstinent
    - L: <6 standard drinks
    - D: >6 standard drinks
    - JA: jail, alcohol related
    - JN: jail, not alcohol related
    - HA: hospital, alcohol related
    - HN: hospital, not alcohol related
    - R: residential treatment

Clients are generally able to recall daily drinking behaviors by identifying anchor points or extended periods of invariant drinking behavior. Similar time-line mechanisms can also be utilized for gathering information about other drug use.

Source: Lettieri, D.J.,Nelson & Sayers M., (1985). *Program Planning and Evaluation.* National Institute on Alcohol Abuse and Alcoholism, Department of Health and Human Services, Washington, D.C.: U.S. Government Printing Office.

ERIC/CASS Clearinghouse to Close

December 31, 2003, will mark the end of a 38-year history of service to counselors and counselor educators by the ERIC Clearinghouse on Counseling and Student Services. Formerly located at The University of Michigan and known as the ERIC Clearinghouse on Counseling and Personnel Services (ERIC/CAPS), it was one of the 13 original ERIC Clearinghouses established in 1966. In 1993, the Clearinghouse was relocated to the University of North Carolina at Greensboro.

Counseling Outfitters to Open

Based on the positive feedback we've received over the years for our publications and workshops, we are convinced that the products and services we have offered through ERIC/CASS meet an important need of counseling professionals. Therefore, we have established a non-profit, educational corporation – Counseling Outfitters – to continue this function. CAPS Press, a major division of Counseling Outfitters, will take over the marketing and sales of current ERIC/CASS (CAPS) publications and will continue the development of new high quality, low cost publications that address emerging issues in counseling.

We will also offer a national workshop in the near future – probably the "hottest" workshop you'll ever attend – since it will most likely be held near our new headquarters in Tucson, Arizona.

Last, but not least, we are exploring ways to continue to offer our award-winning Virtual Libraries.

We are pleased to report that many of these new ventures include a close collaboration with the American Counseling Association Foundation.

For the next few months, we will be focusing on transferring our inventory and resources to Counseling Outfitters. Although we are sorry to see the ERIC system dismantled, we look forward to serving you through an exiting new venue in the future.

Jeanne Bleuer and Garry Walz

U.S. Department of Education
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